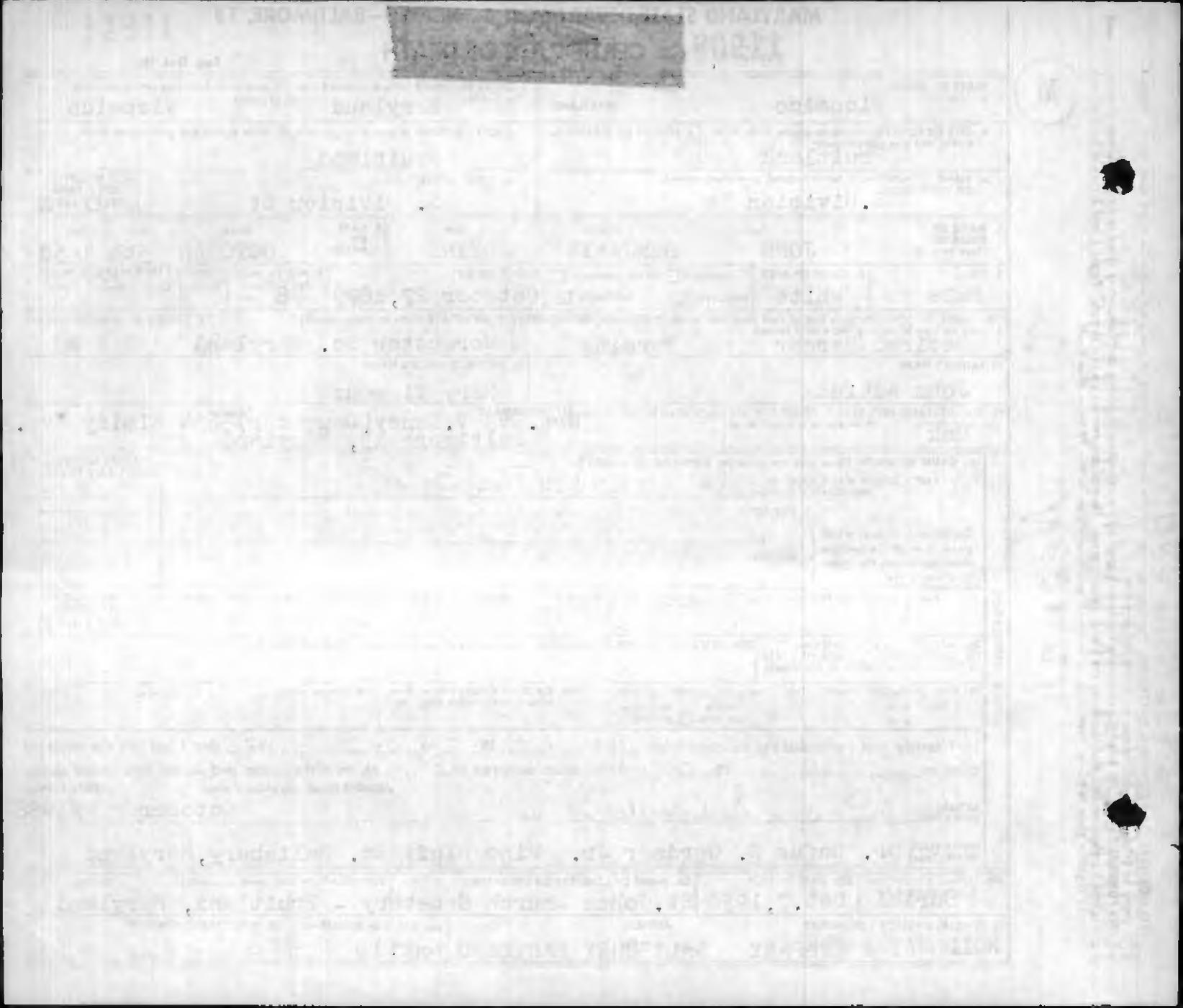


MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
11908 CERTIFICATE OF DEATH

11844

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fruitland		c. LENGTH OF STAY IN 1b RURAL	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION S. Division St		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First JOHN	Middle BENJAMIN	Last ADKINS
4. DATE OF DEATH OCTOBER 5th 1958	Month Month	Day Day	Year Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 27, 1879
9. AGE (In years last birthday) 78 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer	11. KIND OF BUSINESS OR INDUSTRY Farming	12. BIRTHPLACE (State or foreign country) Worcester Co. Maryland
13. FATHER'S NAME John Adkins	14. MOTHER'S MAIDEN NAME Mary Timmons	15. WAS EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Unk	
16. SOCIAL SECURITY NO.	17. INFORMANT Mrs. Eva V. Seney (Daughter) Address Baltimore 13, Maryland	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 492X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO Causa (c) Pneumonia, Belat.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1) Parkinsonism 2) Osteoarthritis			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>March 4, 1958</u> to <u>Oct. 5, 1958</u> , that I last saw the deceased alive on <u>9/30 1958</u> and that death occurred at <u>516 A.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <u>Rufus S. Gardner Jr.</u> M.D.	ADDRESS (Street, city or town, state) Dr. Rufus S. Gardner Jr. Pine Bluff Rd. Salisbury, Maryland DATE SIGNED October 5/1958		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct. 7, 1958	22c. NAME OF CEMETERY OR CREMATORIUM St. Johns Church Cemetery - Fruitland, Maryland	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY	ADDRESS SALISBURY MARYLAND	24a. REC'D BY REGISTRAR OCT 10 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Krause



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11848

CERTIFICATE OF DEATH

11845

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MD</i>		b. COUNTY <i>Maryland</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural and give nearest town Salisbury</i>		c. LENGTH OF STAY IN 1b <i>1 Day</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural and give nearest town Snow Hill</i>		d. STREET ADDRESS <i>Rumsey</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Peninsula General Hospital</i>				d. STREET ADDRESS <i>Rumsey</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>Peggy Sue Ayres</i>		First <i>Peggy</i>	Middle <i>Sue</i>	Lost <i>Ayres</i>	4. DATE OF DEATH <i>October 17 1958</i>	Month <i>October</i>	Day <i>17</i>	Year <i>1958</i>
5. SEX <i>Female</i>		6. COLOR OR RACE <i>Col.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 16-1957</i>	9. AGE (In years lost birthday) yrs. <i>1</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>		11. BIRTHPLACE (State or foreign country) <i>Salisbury, MD</i>		12. CITIZEN OF WHAT COUNTRY? <i>Address</i>		
13. FATHER'S NAME <i>Reece Ayres</i>		14. MOTHER'S MAIDEN NAME <i>Virginia Shaebley</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Ms. Virginia Ayres, Snow Hill, MD</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>491X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		
						INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>		
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <i>Particulars, acute, with dehydration</i>						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>Month, Day, Year 19 1958</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Address</i>		20f. (City or town) <i>Salisbury, MD</i>		
21. I certify that I attended the deceased from <i>17 Oct 1958</i> to <i>17 Oct 1958</i> , that I last saw the deceased alive on <i>Oct 17 1958</i> , and that death occurred at <i>5:30 PM</i> , from the causes and on the date stated above.		22. ADDRESS (Street, city or town, state) <i>202 Cambridge</i>		23. PHYSICIAN'S NAME (Type) <i>R. H. Sanderson, M.D.</i>		24. DATE SIGNED <i>10/17/58</i>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Oct. 1958</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Sayley Cemetery</i>		22d. LOCATION (City, town, or county) <i>Snow Hill</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Elmer L. Evans</i>		ADDRESS <i>Snow Hill, MD</i>		24. REC'D BY REGISTRAR <i>ACT 21 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Carrie L. Evans</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF CALIFORNIA

DEPARTMENT OF STATE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11846

11909 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland		b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pittsville		c. LENGTH OF STAY IN lb 27 Yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Pittsville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION —		d. STREET ADDRESS —		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First EVA	Middle LAVINEA	Last BAKER	4. DATE OF DEATH	Month 10	Day 14	Year 1958
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 6/24/1876	9. AGE (In years last birthday) 82	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James E. Wilkins		14. MOTHER'S MAIDEN NAME Laura Truitt					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Harley Baker, Same		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO Cerebral occlusion		INTERVAL BETWEEN ONSET AND DEATH 10 minutes			
420.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.		(b) DUE TO Hypertension - arteriosclerosis		5-8 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. / p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, form, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1950, 19, to day I died, 19, that I last saw the deceased alive on 10-13, 1958, and that death occurred at 9:15AM, from the causes and on the date stated above.				ADDRESS (Street, city or town, state)		DATE SIGNED 10-14-1958	
ACTUAL SIGNATURE Dr. Frank Lewis		M.D.		Willards, Maryland			
PHYSICIAN'S NAME (Type)		Dr. Frank Lewis		Willards, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/16/58		22c. NAME OF CEMETERY OR CREMATORIUM New Hope Cem.		22d. LOCATION (City, town, or county) (State) Willards, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson Co. Salisbury, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE OCT 17 '58		24b. REGISTRAR'S SIGNATURE Norman F. Baker	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
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 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
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CERTIFICATE OF DEATH

HAWAIIAN STATE GOVERNMENT OF HAWAII - DEPARTMENT OF

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300	301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400	401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448	449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466	467	468	469	470	471	472	473	474	475	476	477	478	479	480	481	482	483	484	485	486	487	488	489	490	491	492	493	494	495	496	497	498	499	500	501	502	503	504	505	506	507	508	509	510	511	512	513	514	515	516	517	518	519	520	521	522	523	524	525	526	527	528	529	530	531	532	533	534	535	536	537	538	539	540	541	542	543	544	545	546	547	548	549	550	551	552	553	554	555	556	557	558	559	560	561	562	563	564	565	566	567	568	569	570	571	572	573	574	575	576	577	578	579	580	581	582	583	584	585	586	587	588	589	590	591	592	593	594	595	596	597	598	599	600	601	602	603	604	605	606	607	608	609	610	611	612	613	614	615	616	617	618	619	620	621	622	623	624	625	626	627	628	629	630	631	632	633	634	635	636	637	638	639	640	641	642	643	644	645	646	647	648	649	650	651	652	653	654	655	656	657	658	659	660	661	662	663	664	665	666	667	668	669	670	671	672	673	674	675	676	677	678	679	680	681	682	683	684	685	686	687	688	689	690	691	692	693	694	695	696	697	698	699	700	701	702	703	704	705	706	707	708	709	710	711	712	713	714	715	716	717	718	719	720	721	722	723	724	725	726	727	728	729	730	731	732	733	734	735	736	737	738	739	740	741	742	743	744	745	746	747	748	749	750	751	752	753	754	755	756	757	758	759	760	761	762	763	764	765	766	767	768	769	770	771	772	773	774	775	776	777	778	779	780	781	782	783	784	785	786	787	788	789	790	791	792	793	794	795	796	797	798	799	800	801	802	803	804	805	806	807	808	809	810	811	812	813	814	815	816	817	818	819	820	821	822	823	824	825	826	827	828	829	830	831	832	833	834	835	836	837	838	839	840	841	842	843	844	845	846	847	848	849	850	851	852	853	854	855	856	857	858	859	860	861	862	863	864	865	866	867	868	869	870	871	872	873	874	875	876	877	878	879	880	881	882	883	884	885	886	887	888	889	890	891	892	893	894	895	896	897	898	899	900	901	902	903	904	905	906	907	908	909	910	911	912	913	914	915	916	917	918	919	920	921	922	923	924	925	926	927	928	929	930	931	932	933	934	935	936	937	938	939	940	941	942	943	944	945	946	947	948	949	950	951	952	953	954	955	956	957	958	959	960	961	962	963	964	965	966	967	968	969	970	971	972	973	974	975	976	977	978	979	980	981	982	983	984	985	986	987	988	989	990	991	992	993	994	995	996	997	998	999	1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
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 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11910 CERTIFICATE OF DEATH

11847

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Delmar		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Wicomico			
c. LENGTH OF STAY IN 1b 40 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Delmar		d. STREET ADDRESS 300 Maryland Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 300 Maryland Ave.		d. STREET ADDRESS 300 Maryland Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Ralph		First Ralph	Middle Ashton	Last Baker	4. DATE OF DEATH Oct. 6	Month Oct.	Day 6	Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 8, 1889	9. AGE (In years last birthday) 69 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0	13. IF UNDER 24 HRS. Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumbing & Heating		10b. KIND OF BUSINESS OR INDUSTRY Heating		11. BIRTHPLACE (State or foreign country) Pittsville, Md.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Noble Baker		14. MOTHER'S MAIDEN NAME Sarah Colling		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO		16. SOCIAL SECURITY NO. 221-10-2504			
				17. INFORMANT Bertha M. Baker, Delmar, Md.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary occlusion INTERVAL BETWEEN Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Coronary arteriosclerosis ONSET AND DEATH 5 min									
DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Delmar		(County) Wicomico	(State) MD
21. I certify that I attended the deceased from 19-53 to 10-6 1958, that I last saw the deceased alive on 9-10 1958, and that death occurred at M. from the causes and on the date stated above. ACTUAL SIGNATURE L. V. Sohler M.D. ADDRESS (Street, city or town, state) 303 East Street, Delmar DATE SIGNED 10-7-58									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-9-58		22c. NAME OF CEMETERY OR CREMATORIAL Red Mens		22d. LOCATION (City, town, or county) Dagsboro, Del.			
23. FUNERAL DIRECTOR'S SIGNATURE W. S. Manley - Delmar, Del.		ADDRESS 100		24a. REC'D BY REGISTRAR DATE Oct 14 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Moore			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11849

CERTIFICATE OF DEATH

11848

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE		Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b Salisbury 203 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Nanticoke	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				d. STREET ADDRESS / --		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First John	Middle Ulie	Last Barclay	4. DATE OF DEATH	Month October	Day 23, 19 58
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 1, 1884	9. AGE (In years last birthday) 74 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Waterman		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Ulie Barclay		14. MOTHER'S MAIDEN NAME Ann Elsey					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Unk.		16. SOCIAL SECURITY NO. 217-14-8227		17. INFORMANT Deer's Head State Hospital, Salisbury, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Pyelonephritis, chronic				INTERVAL BETWEEN ONSET AND DEATH 7	
600.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b)					
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 260 X Diabetes mellitus						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 3, 1958, to October 23, 1958, that I last saw the deceased alive on October 23, 1958, and that death occurred at 7:45 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE Dr. V. Juerman.		M.D.		Deer's Head State Hospital		ADDRESS (Street, city or town, state) DATE SIGNED 10/24/58	
PHYSICIAN'S NAME (Type) V. Juerman, M. D.		Salisbury, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-26-1958		22c. NAME OF CEMETERY OR CREMATORIUM NANTICOKE Cemetery		22d. LOCATION (City, town, or county) NANTICOKE, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE J. P. Stewart Funeral Home, Salisbury, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE OCT 29 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

CLASSIFICATION OF DATA

REF ID: A6412

1

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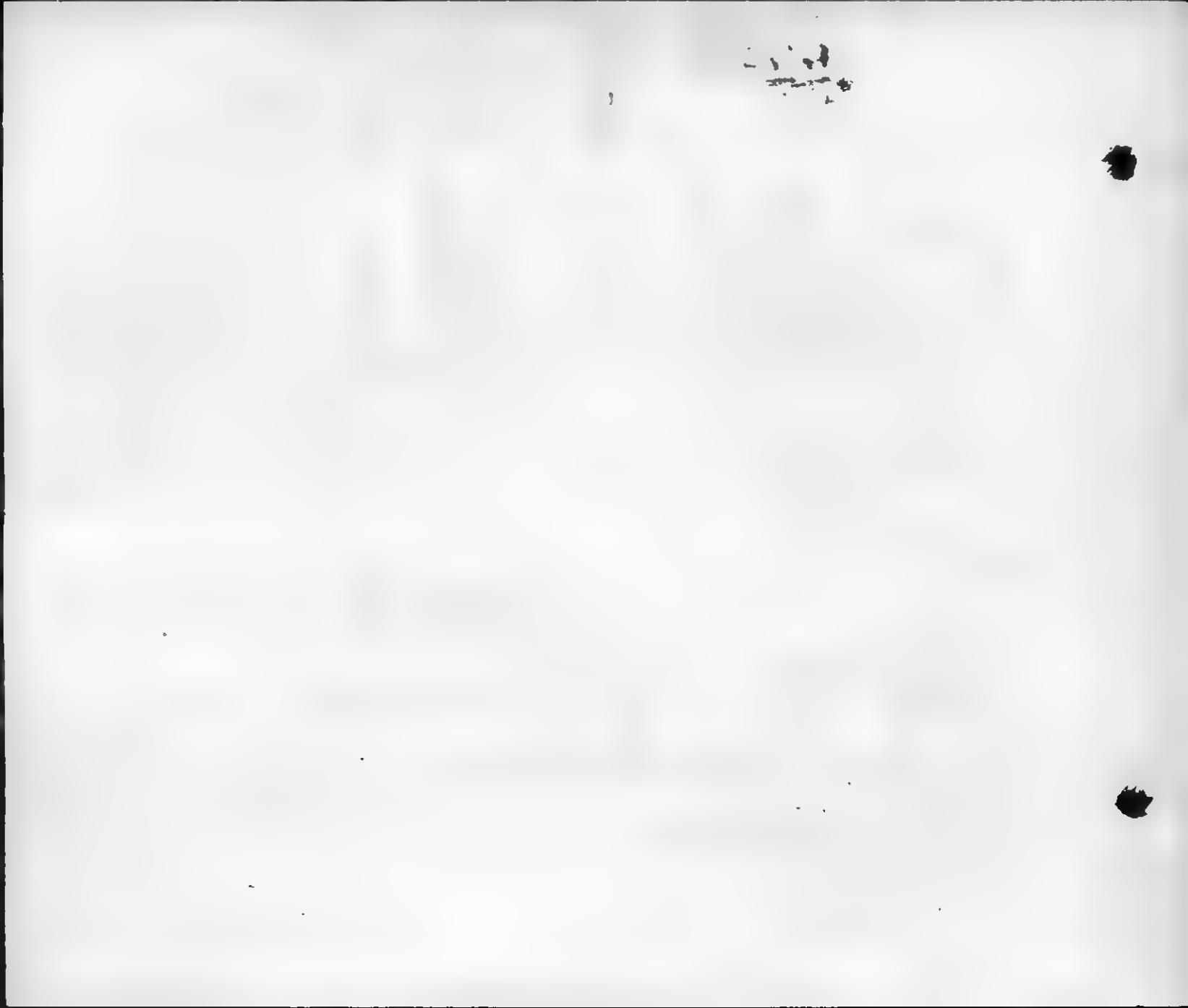
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11849

11850 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		b. COUNTY Wicomico	
c. LENGTH OF STAY IN 1b 2 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 12 Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		d. STREET ADDRESS 407 Clayborn Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Alberta		First	Middle
		Lost	Barkley
4. DATE OF DEATH October 2 1958		Month	Day
5. SEX Female		6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 10/11/1882		9. AGE (In years lost, birthday) 75 yrs	10. IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME Cynthia Wright Baird	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) Unknown		16. SOCIAL SECURITY NO.	17. INFORMANT Hospital Records
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple myeloma DUE TO 15X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH ?	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerotic cardiovascular disease with aortic stenosis, decom.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____ July 29, 1958, to Oct. 2, 1958, that I last saw the deceased alive on _____ Oct. 2, 1958, and that death occurred at 1:20 PM, from the causes and on the date stated above. ACTUAL SIGNATURE Dr. V. Juerman		ADDRESS (Street, city or town, state) M.D. Deer's Head State Hospital 10/2/58 DATE SIGNED	
22. PHYSICIAN'S NAME (Type) V. Juerman, M. D.		Salisbury, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct 6 1958	22c. NAME OF CEMETERY OR CREMATORIAL Seaford Cemetery
22d. LOCATION (City, town, or county) Seaford Del		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE: Brooker H. West		24a. REC'D BY REGISTRAR D OCT 8 '58	24b. REGISTRAR'S SIGNATURE Ortho S. Kline



INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial/transit permit.

VS A15C L-55 10M

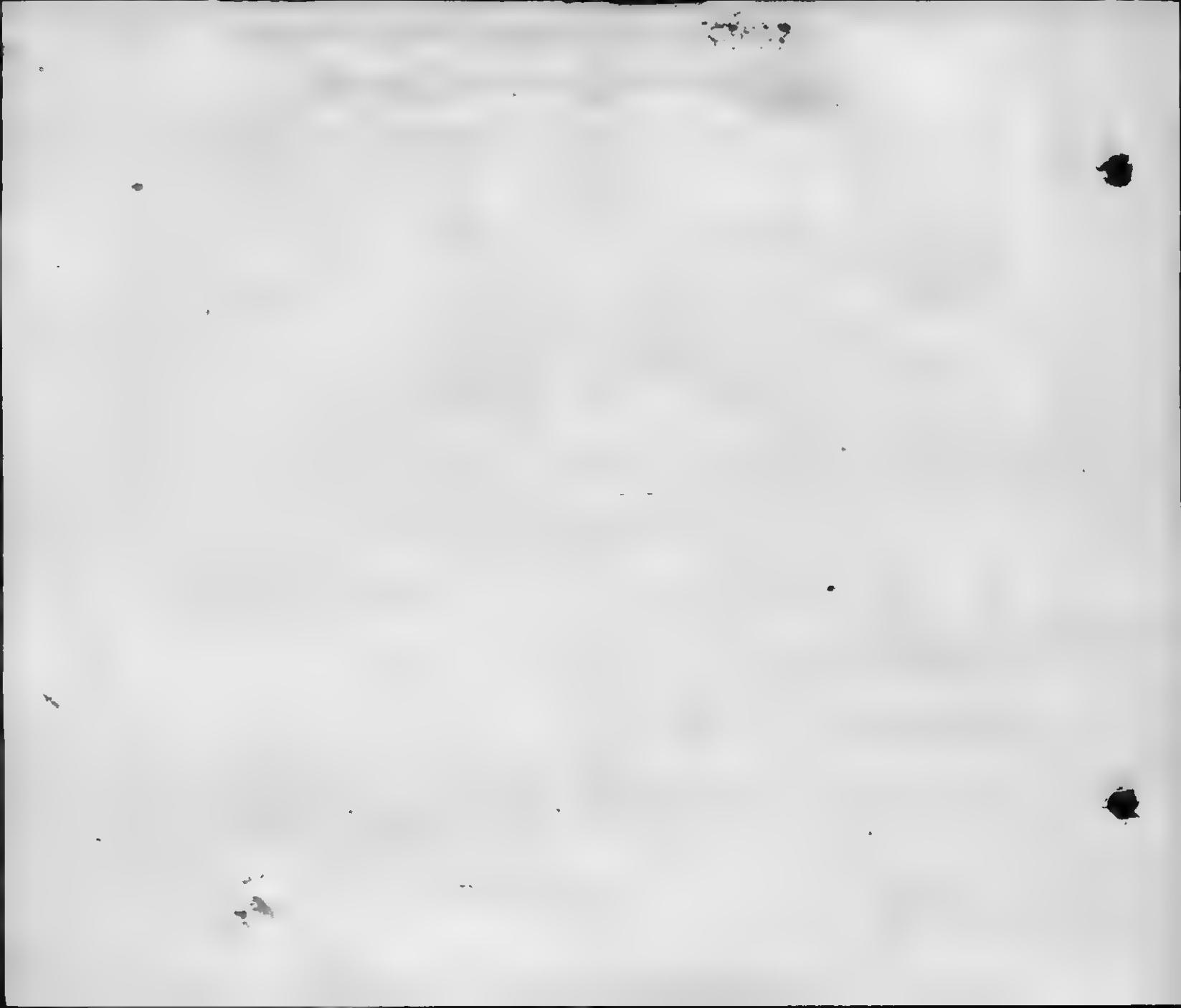
MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11850

11851 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH			2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY	Wicomico	MARYLAND	STATE	Maryland	COUNTY	
CITY (If outside corporate limits, write RURAL or and give nearest town)	LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)	Sonoma, Ca.		
TOWN	Salisbury		Since 10/1/58	TOWN	Deal Island	
HOSPITAL OR INSTITUTION OR STREET ADDRESS	Pine Bluff State Hospital		STREET ADDRESS	(If rural give location)		
Salisbury, Maryland						
3. NAME OF DECEASED (First) (Middle) (Last)			4. DATE OF DEATH (Month) (Day) (Year)			
Minnie Herman Bennett			Oct. 29 1958			
5. SEX		6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	
Female		White	Widowed	August 10, 1975	33 yrs.	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		
Housewife				Deal Island, Maryland		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME			
James G. Webster			Elvora Webster			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS		
No		---		Pine Bluff State Medical Records of Hospital		
18. MEDICAL CERTIFICATION						
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						
IMMEDIATE CAUSE (A) <i>Cerebral Hemorrhage</i>						
ANTECEDENT CAUSE(S) DUE TO						
DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE						
STATING UNDERLYING CAUSE LAST. DUE TO						
(C) <i>Pulmonary Tuberculosis</i>						
INTERVAL BETWEEN ONSET AND DEATH 1 day						
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?		
M.		White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				
22. I hereby certify that I attended the deceased from Oct. 29, 1958, to Oct. 29, 1958, that I last saw the deceased alive on Oct. 29, 1958, and that death occurred at 3:05 P.M. from the causes and on the date stated above.						
SIGNATURE <i>Sam J. Lawrence</i> M.D.						
ADDRESS (Street, city, town, state) <i>Frederick and Md. 10/29/58</i>						
DATE SIGNED						
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	NAME OF CEMETERY	LOCATION (City, town, or county) (State)		
Burial		Nov. 2, 1958	St. John's	Deal Island, Md.		
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		
DATE NOV 5, 1958		Cathleen S. Kline Alice S. Kline		ADDRESS <i>Deal Island, Md.</i>		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11852 CERTIFICATE OF DEATH

11851

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>SALISBURY</i>		c. LENGTH OF STAY IN lb		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>DELAWARE</i>		b. COUNTY <i>Sussex</i>			
						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>FRANKford</i>					
						d. STREET ADDRESS <i>OMAR ROAD</i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Helen</i>		First	Middle	Last	4. DATE OF DEATH <i>October 9, 1958</i>	Month	Day	Year			
5. SEX <i>FEMALE</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3/15/19</i>	9. AGE (In years from birth) <i>39 yrs</i>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours	Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>HOUSEWORK</i>		11. BIRTHPLACE (State or foreign country) <i>DEL.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>					
13. FATHER'S NAME <i>Wm. H. Donaway</i>		14. MOTHER'S MAIDEN NAME <i>Bessie Clegg</i>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO. —		17. INFORMANT <i>CLINTON BREASURE</i>		Address <i>FRANKFORD DEL.</i>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>155.0</i> DUE TO <i>Hegesia Faile</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO <i>Advanced Coronaries of Liver (Panning)</i> (c) <i>jaun.</i>										INTERVAL BETWEEN ONSET AND DEATH <i>Unknown</i> <i>ill first</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <i>—</i>									
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>—</i> 19 p. m. <i>—</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>—</i>		20f. (City or town) <i>—</i>		(County) <i>—</i>	(State) <i>—</i>		
21. I certify that I attended the deceased from <i>—</i> to <i>Oct. 9, 1958</i> , that I last saw the deceased alive on <i>Oct. 9, 1958</i> , and that death occurred at <i>157 M.</i> from the causes and on the date stated above										ADDRESS (Street, city or town, state) <i>—</i>	DATE SIGNED <i>—</i>
ACTUAL SIGNATURE <i>H. D. R. M. Jr., M.D.</i>											
PHYSICIAN'S NAME (Type) <i>—</i>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>10/12/58</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Red Men Cemetery</i>		22d. LOCATION (City, town, or county) <i>Dagsboro - Del.</i>					
23. FUNERAL DIRECTOR'S SIGNATURE <i>Donald James - Millboro - Del.</i>		ADDRESS <i>—</i>		24a. READ BY REGISTRAR DATE <i>Oct. 16 '58</i>		24b. REGISTRAR'S SIGNATURE <i>—</i>					



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11852

11911 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) White Haven		c. LENGTH OF STAY IN 1b Lifetime	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) White Haven	
3. NAME OF DECEASED (Type or print) NORVELL		First H.	Middle COOPER
4. DATE OF DEATH Oct.	Month 31	Day Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/17/1885
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer/ laborer		10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Jonah Cooper		14. MOTHER'S MAIDEN NAME Virginia Davis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO ---	17. INFORMANT Richard Cooper, Salisbury, Maryland
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) L20.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 5 min.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) pulmonary tuberculosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Oct 13, 1958, to Oct 31, 1958, that I last saw the deceased alive on Oct 31, 1958, and that death occurred at 12 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. 71 Camellia Ave Nov 3 '58 DATE SIGNED			
ACTUAL SIGNATURE Alberta Mattax		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
22b. DATE THEREOF 11/3/58		22c. NAME OF CEMETERY OR CREMATORIUM Rockawalkin Cem.	
22d. LOCATION (City, town, or county) Rockawalkin, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE C. J. Messier		24a. REC'D BY REGISTRAR DATE NOV 5 '58	
ADDRESS Bivalve, Maryland		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11853

11853

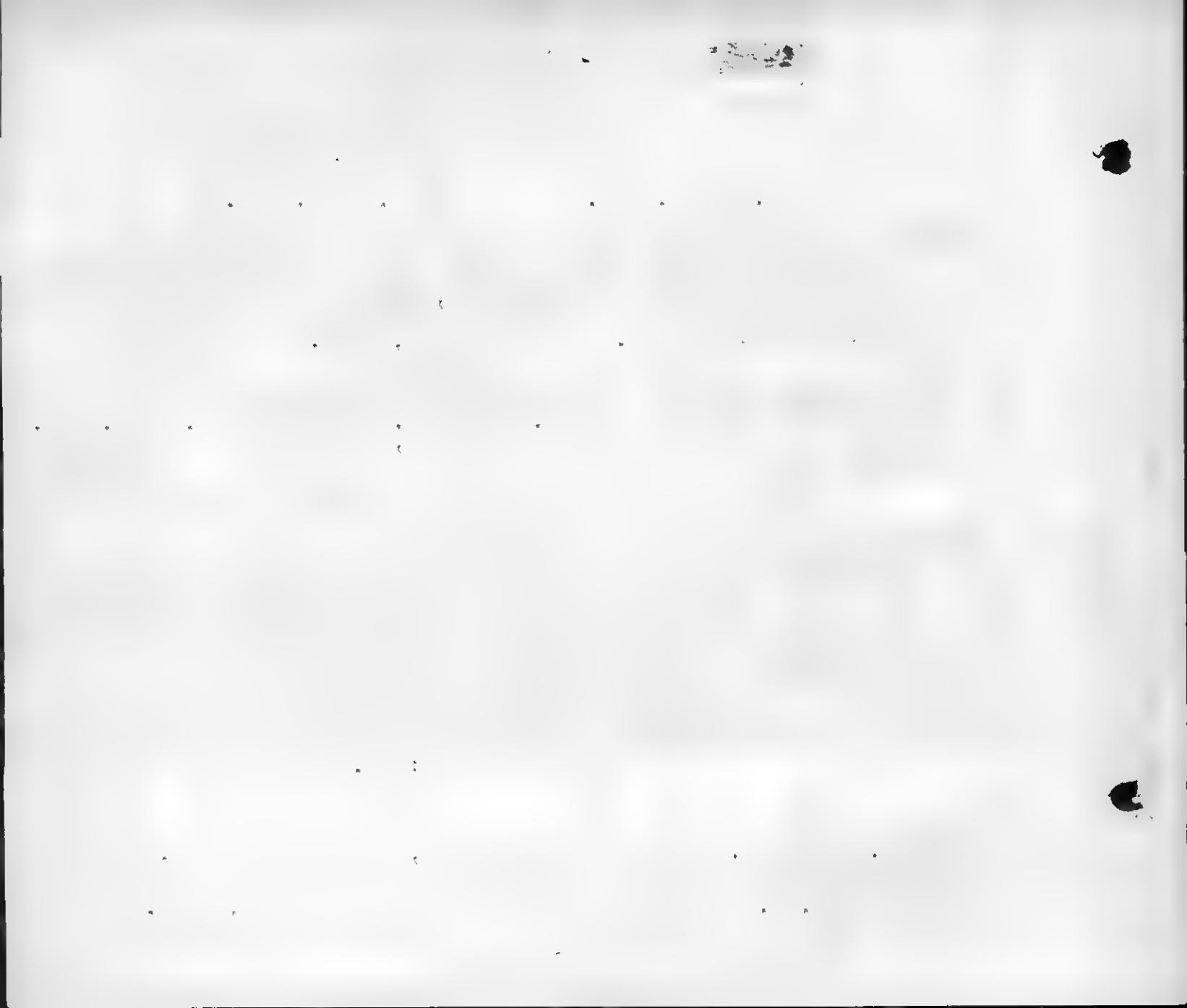
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		b. COUNTY Wicomico	
c. LENGTH OF STAY IN 1b Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 219 W. Phila. Ave.		d. STREET ADDRESS 219 W. Phila. Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First ERNEST	Middle CUSHING	Last DANA
4. DATE OF DEATH	Month OCTOBER	Day 22nd	Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 30, 1873
9. AGE (In years last birthday) 85	10. IF UNDER 1 YEAR Months 3	11. IF UNDER 24 HRS Days 22	12. IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman -Retired-	10b. KIND OF BUSINESS OR INDUSTRY Feed Co.	11. BIRTHPLACE (State or foreign country) Chelsea, Mass.	
13. FATHER'S NAME Francis William Dana		14. MOTHER'S MAIDEN NAME Olive Locke Neale	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO.	17. INFORMANT Mr. Richard C. Dana (Son)	18. ADDRESS 219 W. Phila. Ave. Salisbury, Maryland
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
<i>Cardiac Insufficiency</i>			
<i>Myocardial Disease</i>			
<i>Hypertensive C.V. disease</i>			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from _____ to _____ that I last saw the deceased alive on _____ and that death occurred at _____ from the causes and on the date stated above.			
ACTUARIAL SIGNATURE <i>Wm. B. Smith</i>	ADDRESS (Street, city or town, state) <i>Wm. B. Smith, M.D., 219 W. Phila. Ave., Salisbury, Maryland</i>	DATE SIGNED <i>18/2/58</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 25, 1958	
22c. NAME OF CEMETERY OR CREMATORIAL Lawncroft Cemetery		22d. LOCATION (City, town, or county) Bridgeport, Conn.	
(State)		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND	
24a. REC'D BY REGISTRAR Oct 27 '58		24b. REGISTRAR'S SIGNATURE <i>John S. Kraus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by hospital or attending physician
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11854 CERTIFICATE OF DEATH

11854
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury, Maryland		b. COUNTY Wicomico	
c. LENGTH OF STAY IN 1b 3 yrs 14 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury, Maryland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		d. STREET ADDRESS 510 Rose Street	
3. NAME OF DECEASED (Type or print) Moses		First Middle William	4. DATE OF DEATH Oct. 5, 1958
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 30, 1863
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gardening		10b. KIND OF BUSINESS OR INDUSTRY unk	
11. BIRTHPLACE (State or foreign country) Maryland		9. AGE (In years from birthday) 95 yrs.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Moses Dashiell	14. MOTHER'S MAIDEN NAME Flora Robinson
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unk		16. SOCIAL SECURITY NO unk	17. INFORMANT Hospital Records
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal Insufficiency 600.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) Pyelonephritis chr. (c)		INTERVAL BETWEEN ONSET AND DEATH 5 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerotic Cardiovascular disease w/aortic sclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Sept. 21, 1955, to Oct. 5, 1958, that I last saw the deceased alive on Oct. 5, 1958, and that death occurred at 5:25 AM, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Salisbury, Maryland	
ACTUAL SIGNATURE Dr. V. Juerman	M.D.		DATE SIGNED 10/5/58
PHYSICIAN'S NAME (Type) V. Juerman, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct 8-58	22c. NAME OF CEMETERY OR CREMATORIUM Stratford Cemetery	22d. LOCATION (City, town, or county) Towson
23. FUNERAL DIRECTOR'S SIGNATURE Brooks & Clark		ADDRESS	24a. REC'D BY REGISTRAR DATE Oct 14, 1958
			24b. REGISTRAR'S SIGNATURE Audra L. Evans



TO DEPUTY MEDICAL EXAMINER: This certificate should be submitted within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for reference.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11855 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11856

Reg. Dist. No.

Items 18, 20 & 21, File G-235 10/27/58 rev.

1. PLACE OF DEATH
a. COUNTY

Wicomico

MARYLAND

2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission)

a. STATE Maryland

b. COUNTY

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Salisbury

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Peninsula General Hospital

3. NAME OF
DECEASED
(Type or print)

First

Middle

Charles

Lee

Davis

Last

4. DATE
OF
DEATH

10-9-

19 58

5. SEX

M

6. COLOR OR RACE

W

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

MAR. 13, 1956

9. AGE (In years
from birthday)

21

10. UNDER 1 YEAR

2 yrs

IF UNDER 24 HRS

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

CHARLES H. DAVIS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)

16. SOCIAL SECURITY NO. (If yes, give war or dates of service)

17. INFORMANT

Address

14. MOTHER'S MAIDEN NAME

DOROTHY MERRITT

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

4-6-0

Poisoning

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause first.

(b)

Sodium Arsenite

DUE TO

(c)

INTERVAL BETWEEN
ONSET AND DEATH

5 hours

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY
PERFORMED? YES NO

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

Drank from soft drink bottle used to mix weed killer.

20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m.

20d. INJURY OCCURRED

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

While at work Not while at work

Farm

Berlin, Worcester Co., Md.

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

22e. BURIAL, CREMATION OR
ANOTHER (Specify)

BURIAL

22f. DATE THEREOF

10/11/58

BETH EDEN

22g. NAME OF CEMETERY OR CREMATORIUM

ADDRESS

M.D. CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

10-10-58

23. FUNERAL DIRECTOR'S SIGNATURE

Barbara D. Burley

Berlin, Md.

ADDRESS

24a. REC'D BY REGISTRAR

DATE OCT 14 '58

24b. REGISTRAR'S SIGNATURE

Arthur S. Kraus



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11856 CERTIFICATE OF DEATH

Reg. Dist. No. 11857

1. PLACE OF DEATH o COUNTY Wicomico		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		b. COUNTY Wicomico	
c. LENGTH OF STAY IN 1b /		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen. Gen. Hospital		d. STREET ADDRESS / 906 Register St	
e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First VICTOR	Middle MC LAIN	Last DEAN
4. DATE OF DEATH	Month OCTOBER	Day 4th	Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 9, 1910
9. AGE (In years at birthday) 48 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self Employed		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Wingate, Maryland	
13. FATHER'S NAME Richard Dean		14. MOTHER'S MAIDEN NAME Lehr Holliday	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO.	17. INFORMANT Mrs. Rosezena Dean (Wife) 806 Register St Salisbury, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Lobar Pneumonia		1 day	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Malignant Tumor of Abdominal Lymph Nodes, 1 year DUE TO Unclassified. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 410 X		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Doy, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) Salisbury		(County) (State) Wicomico Maryland	
21. I certify that I attended the deceased from Oct. 1, 1958, to Oct. 4, 1958, that I last saw the deceased alive on Oct. 4, 1958, and that death occurred at 6:45 A.M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 222 N. Division St. Salisbury, Md.	
ACTUAL SIGNATURE <i>Paul G. Cayaves, M.D.</i>		DATE SIGNED Oct. 5, 1958	
22e. PHYSICIAN'S NAME (Type) Dr. Paul G. Cayaves		22f. LOCATION (City, town, or county) (State) Salisbury, Maryland	
22g. BURIAL, CREMATION, OR REMOVAL (Specify) Burial Oct. 8, 1958		22h. NAME OF CEMETERY OR CREMATORIUM Wicomico Memorial Park	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		24a. ADDRESS SALISBURY MARYLAND	
		24b. REC'D BY REGISTRAR DATE OCT 10 '58	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
11912 CERTIFICATE OF DEATH

11858

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Tyaskin		c. LENGTH OF STAY IN 1b Lifetime		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MARYLAND		b. COUNTY Wicomico	
						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Tyaskin			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 				d. STREET ADDRESS 				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) GERTRUD...		First	Middle	Last	4. DATE OF DEATH Oct. 29 1958	Month	Day	Year	
5. SEX Female		6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/9/1880	9. AGE (In years last birthday) 78 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME John Elsey		14. MOTHER'S MAIDEN NAME Unknown							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----		17. INFORMANT Leonard Brown, Tyaskin, Maryland		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		Debile Coronary Occlusive. Antemortem Heart Disease. 10 Years.		INTERNAL BETWEEN ONSET AND DEATH 10 years.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month Day Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 		20f. (City or town) 		(County)	(State)
21. I certify that I attended the deceased from 4 Aug 1947 to 29 Oct 1958 that I last saw the deceased alive on 29 Oct 1958 , and that death occurred at 1A M. from the causes and on the date stated above.								ADDRESS (Street, city or town, state) Nanticoke Md.	
ACTUAL SIGNATURE Richard H. Saunders								DATE SIGNED 10/30/58	
PHYSICIAN'S NAME (Type) Richard H. Saunders		Nanticoke, Maryland 10/30/58							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/2/58		22c. NAME OF CEMETERY OR CREMATORIAL Tyaskin Cem.		22d. LOCATION (City, town, or county) Tyaskin, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Carl Messick		ADDRESS Bivalve, Maryland		24a. REGD BY REGISTRAR Nov 5 30		24b. REGISTRAR'S SIGNATURE Clinton S. Price			
				DATE					



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11857

CERTIFICATE OF DEATH

Reg. Dist. No. 11859

1. PLACE OF DEATH a. COUNTY Wicomico		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MD		b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OCEAN CITY RFD		d. STREET ADDRESS OCEAN CITY BLVD			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula General Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First EDWARD	Middle M.	Lost Fears	4. DATE OF DEATH October 24 1958	Month Oct	Day 24	Year 1958	
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Oct. 6, 1895	9. AGE (In years lost birthday) 63 yrs	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INTERIOR DECORATOR		10b. KIND OF BUSINESS OR INDUSTRY SELF EMPLOYED		11. BIRTHPLACE (State or foreign country) JONESBORO, ARK.		12. CITIZEN OF WHAT COUNTRY U.S.A.			
13. FATHER'S NAME ALFRED B. FEARS				14. MOTHER'S MAIDEN NAME ALICE VIRGINIA					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) Yes		16. SOCIAL SECURITY NO. World War 2 327-12-2338		17. INFORMANT Mr. Fred Fears OCEAN CITY, MO		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH Myocardial Infarct, acute (day)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1		DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b)									
DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. m. p. m.		Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) BERLIN	(County) MD	(State)
21. I certify that I attended the deceased from <u>Oct 23</u> , 1958, to <u>Oct 24</u> , 1958, that I last saw the deceased alive on <u>Oct 24</u> , 1958, and that death occurred at <u>11:40</u> AM, from the causes and on the date stated above.		ADDRESS (Street, city or town, state)						DATE SIGNED	
ACTUAL SIGNATURE William J. Elifit MD.									
PHYSICIAN'S NAME (Type)									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/27/58		22c. NAME OF CEMETERY OR CREMATORIUM EVANGELICAN		22d. LOCATION (City, town, or county) BERLIN		(State) MD	
23. FUNERAL DIRECTOR'S SIGNATURE Anna H. Burbage Berlin Md		ADDRESS		24a. REC'D BY REGISTRAR DATE OCT 28 '58		24b. REGISTRAR'S SIGNATURE C. J. - 94-111			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-trust permit. Then please remove carbon paper
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

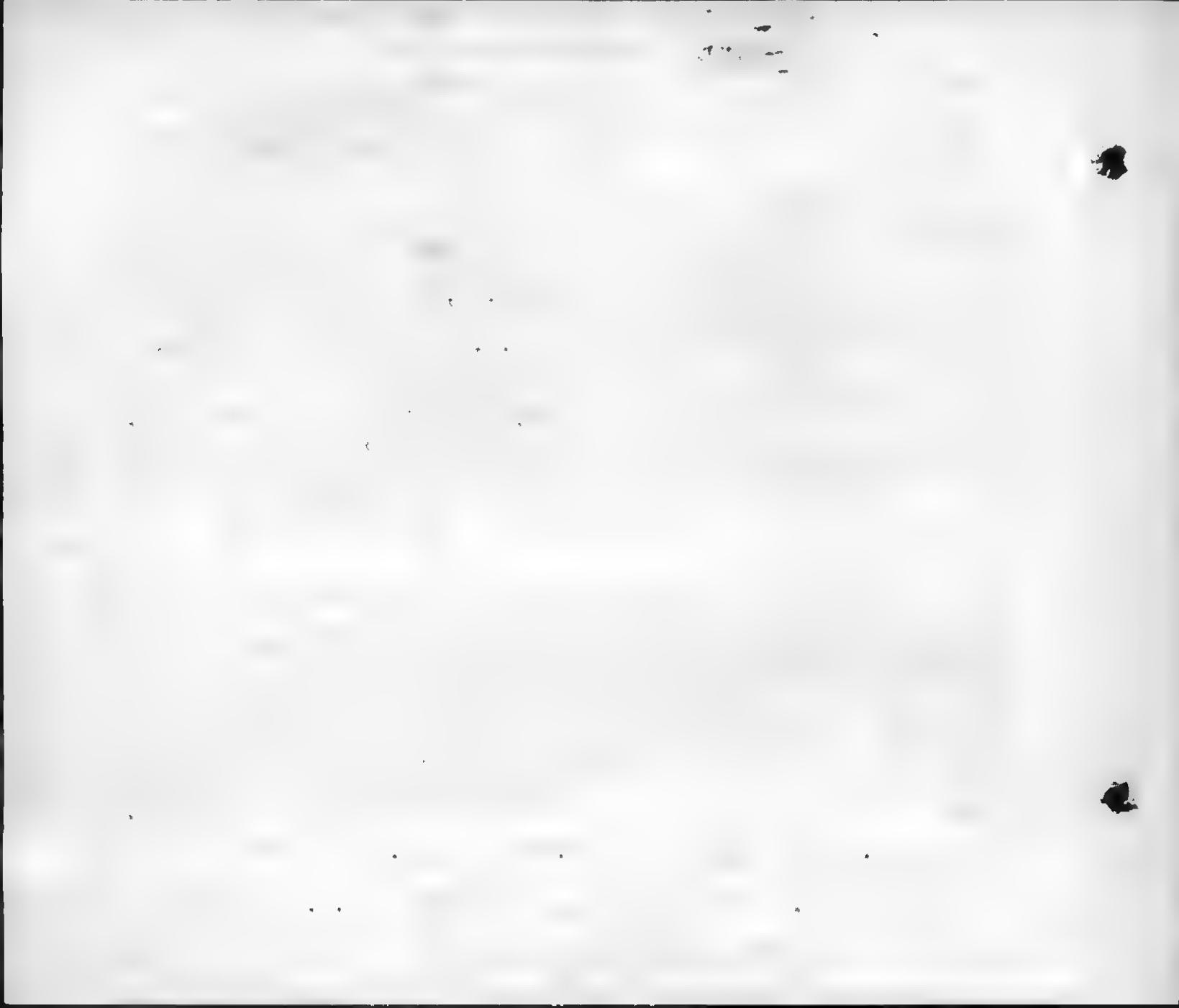
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11858 CERTIFICATE OF DEATH

Reg. Dist. No. 11860

1. PLACE OF DEATH a. COUNTY Wicomico		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		b. COUNTY Wicomico	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury (Rural)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glen St		d. STREET ADDRESS Glen St	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First EDDIE	Middle LEE	Last FIELDS
4. DATE OF DEATH	Month October	Day 26th	Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 1, 1874
9. AGE (In years to nearest birthday) 84 yrs	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Building	
11. BIRTHPLACE (State or foreign country) R.D. #(Shad Point) Salisbury, Md		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME William Fields		14. MOTHER'S MAIDEN NAME Henrietta Fields	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) No		16. SOCIAL SECURITY NO Mrs. Nettie Fields (Wife) ^{Address} Glen St. Salisbury, Maryland	
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 199.1 DUE TO Basal cell carcinoma of left shoulder 1958		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, 19____, from the causes and on the date stated above.			
ACTUAL SIGNATURE Dr. Fred Gramse		ADDRESS (Street, city or town, state) Salisbury, Md DATE SIGNED Oct. 30 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Oct. 29, 1958		22b. DATE THEREOF Shad Point Cemetery	
22c. NAME OF CEMETERY OR CREMATORIAL R.D. #		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND	
24a. REC'D BY REGISTRAR DATE NOV 3 '58		24b. REGISTRAR'S SIGNATURE C. E. T. & T. 2	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4, may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11859

CERTIFICATE OF DEATH

11861

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Caroline</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, residence before admission) a. STATE <i>Md.</i>		b. COUNTY <i>Caroline</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>		c. LENGTH OF STAY IN 1b <i>1 day</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Caroline</i>		d. STREET ADDRESS <i>None</i>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Peninsula Memorial Hospital</i>				d. STREET ADDRESS <i>None</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First <i>Harry</i>	Middle <i></i>	Last <i>Farmerman</i>	4. DATE OF DEATH <i>October 12 1958</i>	Month <i>Oct.</i>	Day <i>12</i>	Year <i>1958</i>			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 6 1897</i>		9. AGE (In years from birthday), yrs <i>61 yrs</i>	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <i></i>	Days <i></i>	Hours <i></i>	Min. <i></i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Cab driver</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Driving factory</i>		11. BIRTHPLACE (State or foreign country) <i>Nevada, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>None</i>					
13. FATHER'S NAME <i>Sidney Farmerman</i>		14. MOTHER'S MAIDEN NAME <i>Mary Gredow</i>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <input type="checkbox"/> (Yes, no, or discharge) <i>No</i>		16. SOCIAL SECURITY NO <i>710-11-443X</i>		17. INFORMANT <i>Fireman</i>		Address <i>William J. Farmerman, 1100 W. 36th St., Baltimore, Md.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Acute cardiac dilatation</i>					INTERVAL BETWEEN ONSET AND DEATH <i>2 hr.</i>				
		DUE TO <i>Chronic congestive heart failure</i>					4 weeks				
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>491x</i>		(b) <i>Massive pleural effusion</i>									
		DUE TO <i>Hypertension arterio-sclerotic C.V. disease</i>					Year <i>1 yr</i>				
19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)									
20c. TIME OF INJURY Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>None</i>		(County) <i></i>		(State) <i></i>	
21. I certify that I attended the deceased from alive on <i>10/11/58</i>		10/11/58		to <i>10/11/58</i>		that I last saw the deceased and that death occurred at <i>11/15/58</i> 2M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i></i>		DATE SIGNED <i></i>	
ACTUAL SIGNATURE <i>John Farmerman</i>		M.D.									
PHYSICIAN'S NAME (Type)											
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>10/11/58</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Calvert Cemetery</i>		22d. LOCATION (City, town, or county) <i>None</i>		(State) <i></i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>George Johnson</i>		ADDRESS <i>Scarsdale, Md.</i>				24a. REC'D BY REGISTRAR <i>OCT 16 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be reigned by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the Burial-Transit Permit. Then please remove carbon papers. Page 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
11860 CERTIFICATE OF DEATH

11862
 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 1 Day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		d. STREET ADDRESS Park Ave., Apts.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula General Hospital				e. DATE OF DEATH 10 18 1958		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ETHEL TULL FOSTER		First	Middle	Last	Month	Day	Year		
4. SEX Female		5. COLOR OR RACE White	6. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	7. DATE OF BIRTH Nov. 11, 1891	8. AGE (In years lost birthday) 66 yrs.	9. IF UNDER 1 YEAR Months	10. IF UNDER 24 HRS Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Army Nurse		10b. KIND OF BUSINESS OR INDUSTRY Nurse		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Wm. Alfred Tull				14. MOTHER'S MAIDEN NAME Stella K. Tull					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Type or print or date of service) YES WWT		16. SOCIAL SECURITY NO NONE		17. INFORMANT Mrs. S. King White		Address Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH 1 day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from 10-17, 1958 to 10-18, 1958 , that I last saw the deceased alive on 10-18, 1958 , and that death occurred at M , from the causes and on the date stated above. ACTUAL SIGNATURE Wilber R. Ellis, Jr. PHYSICIAN'S NAME (Type) Wilber R. Ellis, Jr.		ADDRESS (Street, city or town, state) Salisbury, Md.						DATE SIGNED 10-1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/20/1958		22c. NAME OF CEMETERY OR CREMATORIUM St. Pauls Cemetery		22d. LOCATION (City, town, or county) Marion Station, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson Co. Salisbury, Maryland		ADDRESS George C. Hill II		24a. REC'D BY REGISTRAR DATE OCT 21 58		24b. REGISTRAR'S SIGNATURE George C. Hill II			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11863

11861

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 1 day		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Wicomico		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital						d. STREET ADDRESS 521 Gordon Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First Charles	Middle Alexander	Last Frazier	4. DATE OF DEATH October 21, 1958	Month Year	5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 19, 1904	9. AGE (In years lost birthday) 54 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY M		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA						
13. FATHER'S NAME Robert Frazier		14. MOTHER'S MAIDEN NAME Sarah Elizabeth Keys										
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no, or unknown) Unknown		16. SOCIAL SECURITY NO. 217-10-3617		17. INFORMANT Deer's Head State Hospital, Salisbury, Md.		Address						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 161X		Carcinoma of larynx, advanced				INTERVAL BETWEEN ONSET AND DEATH 1 yr.						
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b) DUE TO										
(c) DUE TO												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)										
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)						
21. I certify that I attended the deceased from October 20, 1958, to October 21, 1958, that I last saw the deceased alive on October 21, 1958, and that death occurred at 12:55 AM, from the causes and on the date stated above.				ADDRESS (Street, city or town, state)		DATE SIGNED						
ACTUAL SIGNATURE Dr. V. Juerman		M.D.		Deer's Head State Hospital		10/21/58						
PHYSICIAN'S NAME (Type) V. Juerman, M. D.				Salisbury, Maryland								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-23-58		22c. NAME OF CEMETERY OR CREMATORIUM Front Porch Cemetery		22d. LOCATION (City, town, or county) Patuxent						
23. FUNERAL DIRECTOR'S SIGNATURE Jackie St. Clair		ADDRESS		24a. REC'D BY REGISTRAR OCT 29 '58		24b. REGISTRAR'S SIGNATURE Elaine S. Hause						

TO HOSPITAL OR ATTENDING PHYSICIAN—The law requires that the death certificate be executed within 24 hours after death. Page 4
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 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
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 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



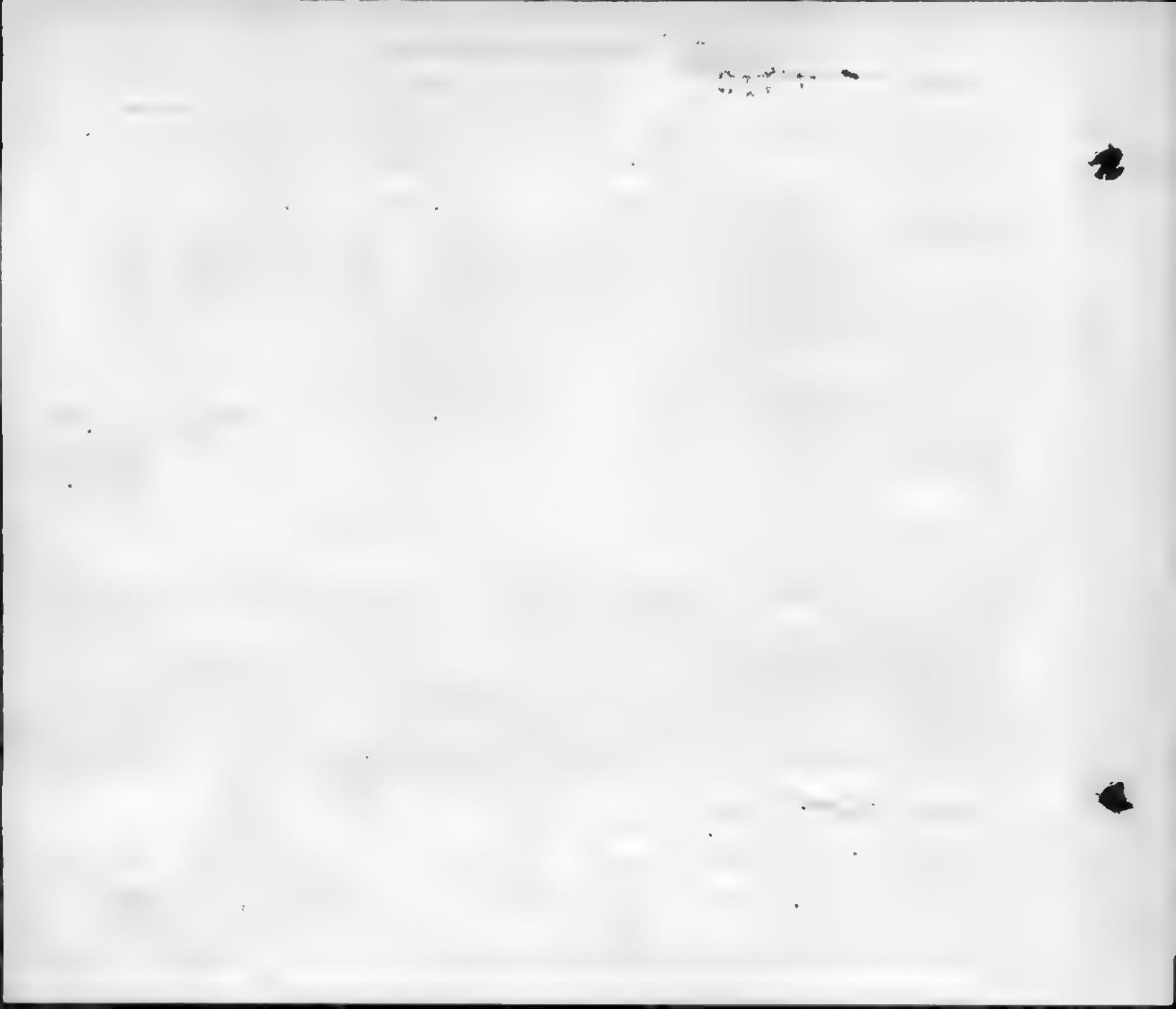
MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11862 CERTIFICATE OF DEATH

11864

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland		b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury, Maryland		c. LENGTH OF STAY IN 1b 1 mo. 22 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury, Maryland			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		d. STREET ADDRESS 107 E. Isabella St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Edna	First	Middle Owens	Last Fulton	4. DATE OF DEATH 4/1/1879	Month October	Day 10	Year 1958
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/1/1879	9. AGE (In years last birthday) 79 yrs	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saleslady		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Owens		14. MOTHER'S MAIDEN NAME Martha Porter					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Mrs. Jean Truitt-Brewington Drive Salisbury, Md. Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cor Pulmonale 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Arteriosclerotic Cardiovascular disease DUE TO (c) Carcinoma of head of pancreas PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 18, 1958, to October 10, 1958, that I last saw the deceased alive on October 10, 1958, and that death occurred at 11:10 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE G. Kornwall M.D. ADDRESS (Street, city or town, state) Salisbury, Maryland DATE SIGNED 10/11/58							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 13/58		22c. NAME OF CEMETERY OR CREMATORIUM Parsons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND		24a. REC'D BY REGISTRAR DATE OCT 14 '58		24b. REGISTRAR'S SIGNATURE C. L. Klaus	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11863

CERTIFICATE OF DEATH

Reg. Dist. No.

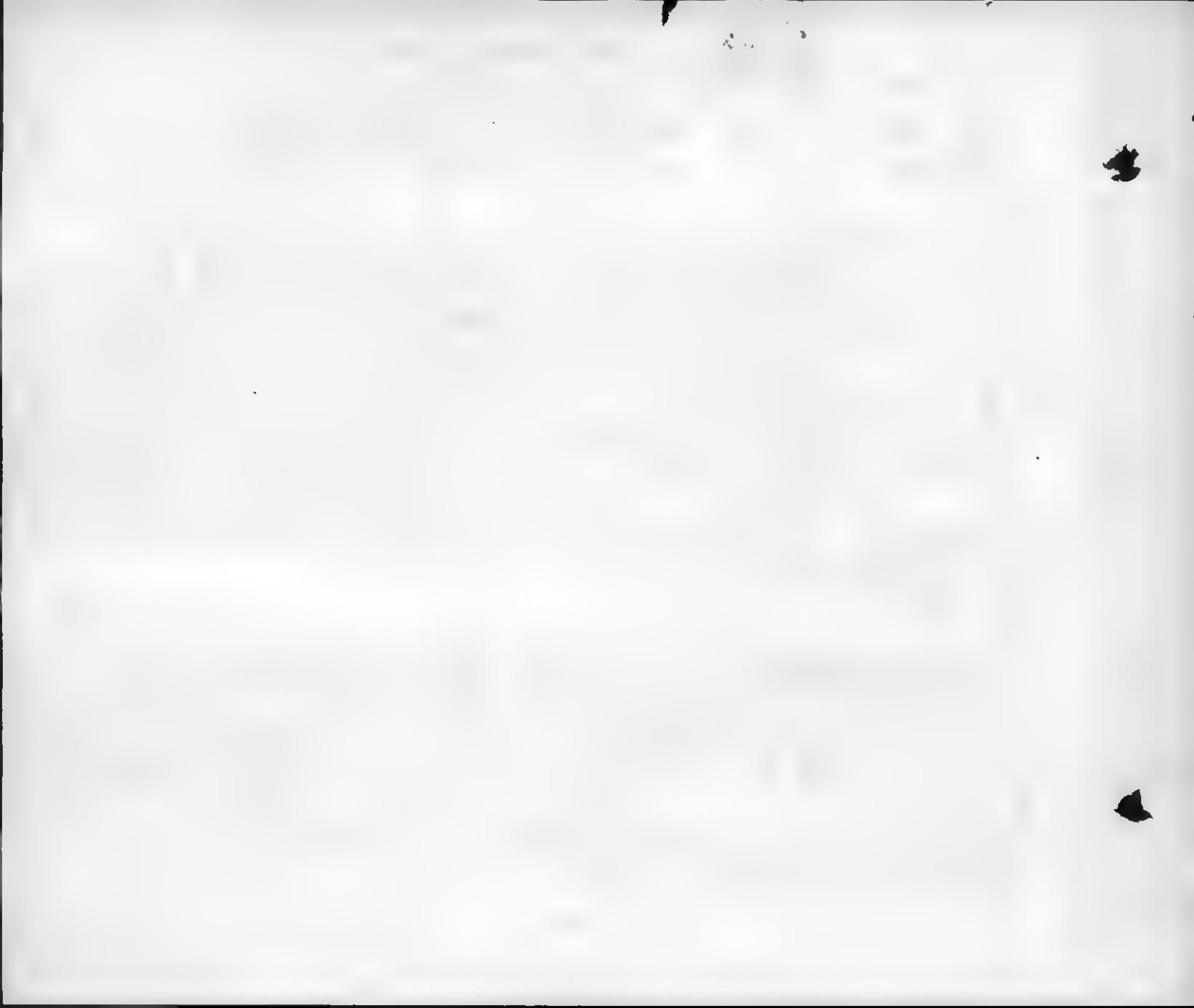
11865

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Worcester</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>		c. LENGTH OF STAY IN 1b <i>3 weeks</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Berlin</i>		d. STREET ADDRESS			
d. NAME OF HOSPITAL (If not in hospital, give street address) <i>Peninsula General Hospital</i>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>Charles</i>		First <i>E.</i>	Middle <i></i>	Lost <i></i>	4. DATE OF DEATH <i>October 29 1958</i>	Month <i>October</i>	Day <i>29</i>	Year <i>1958</i>	
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>JAN. 1 1878</i>	9. AGE (in years lost birthday) <i>80 yrs</i>	10. IF UNDER 1 YEAR Months <i></i>	11. IF UNDER 24 HRS Days <i></i>	12. HRS Hours <i></i>	13. MIN
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Farm</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore Maryland</i>		12. CITIZEN OF WHAT COUNTRY <i>U. S. A</i>			
13. FATHER'S NAME <i>WILLIAM H. HADDER</i>		14. MOTHER'S MAIDEN NAME <i>Mary C. WIGGON</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or date of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>No</i>		17. INFORMANT <i>Mr. THOMAS HADDER SHAWNEE MD</i>		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Uremia</i>		DUE TO <i>Chronic glomerulonephritis</i>				INTERVAL BETWEEN ONSET AND DEATH <i>2 weeks</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)						Years.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Berlin</i>		(County) <i></i>	
20g. (State) <i>MD</i>									
21. I certify that I attended the deceased from <i>10/28/58</i> to <i>10/29/58</i> , that I last saw the deceased alive on <i>10/28/58</i> , and that death occurred at <i>12 PM</i> , from the causes and on the date stated above ACTUAL SIGNATURE <i>John</i>		ADDRESS (Street, city or town, state) <i></i>		DATE SIGNED <i></i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>10/31/58</i>		22c. NAME OF CEMETERY OR CEMETORY <i>Taylor Service</i>		22d. LOCATION (City, town, or county) <i>Berlin</i>		(State) <i>MD</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Anna D. Bubage Berlin Md</i>		ADDRESS <i></i>		24a. REC'D BY REGISTRAR <i>NOV 3 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
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 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G 35 10/11/58 gr

11866

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE	
Wicomico MARYLAND		Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
c. LENGTH OF STAY IN lb 30 yrs		d. STREET ADDRESS 215 Newton St.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 215 Newton St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Stephen		First	Middle
4. DATE OF DEATH		Month	Day
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
Female		White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH		9. AGE (In years at death) 86	
Oct 23 1871		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Robert Pritchett	
14. MOTHER'S MAIDEN NAME Pauline Webster		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Wendell Humphreys	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 552X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		19. INTERVAL BETWEEN ONSET AND DEATH 6 mo	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/8/58, 1958, to 10/24/58, 1958, that I last saw the deceased alive on 10/24/58, 1958, and that death occurred at Salisbury, Md., from the causes and on the date stated above. ACTUAL SIGNATURE Physician's NAME (Type) John Wesley		ADDRESS (Street, city or town, state) Salisbury, Md. DATE SIGNED 10/24/58	
22. BURIAL, CREMATION, REMOVAL (Specify) Burial Oct 25 1958		22c. NAME OF CEMETERY OR CREMATORIAL John Wesley	
22d. LOCATION (City, town, or county) Mt. Vernon		(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. L. Kline		24a. REC'D BY REGISTRAR DATE OCT 22 1958	
24b. REGISTRAR'S SIGNATURE John L. Kline			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11867

11865 CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

1. PLACE OF DEATH a. COUNTY Wicomico		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland		b. COUNTY Wicomico		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN lb 843 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		d. STREET ADDRESS 697 Fitzwater Street		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Lillian		First	Middle	Lost	4. DATE OF DEATH Oct. 30	Month	Day	Year
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 8/8/1899	9. AGE (In years lost birthday) 59 yrs.	IF UNDER 1 YEAR / IF UNDER 24 HRS		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Joseph Dinstan		14. MOTHER'S MAIDEN NAME Trieze						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -		16. SOCIAL SECURITY NO.		17. INFORMANT Hospital Records Address Mr. Ernest J. Disharoon (Son) R.D. #5 (Parker Rd.) Salisbury, Maryland				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 422.1 DUE TO Arteriosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Arteriosclerosis, general (c)						INTERVAL BETWEEN ONSET AND DEATH Years		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Hour e. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from July 9, 1956, to Oct. 30, 1958, that I last saw the deceased alive on October 30, 1958, and that death occurred at 10:45 P.M., from the causes and on the date stated above.						ADDRESS (Street, city or town, state) DATE SIGNED Deer's Head State Hospital 10/31/58		
ACTUAL SIGNATURE L. V. Maldve, M. D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 3, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Parsons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND		24a. REC'D BY REGISTRAR DATE NOV 3 '58		24b. REGISTRAR'S SIGNATURE C. S. Kraus		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11868

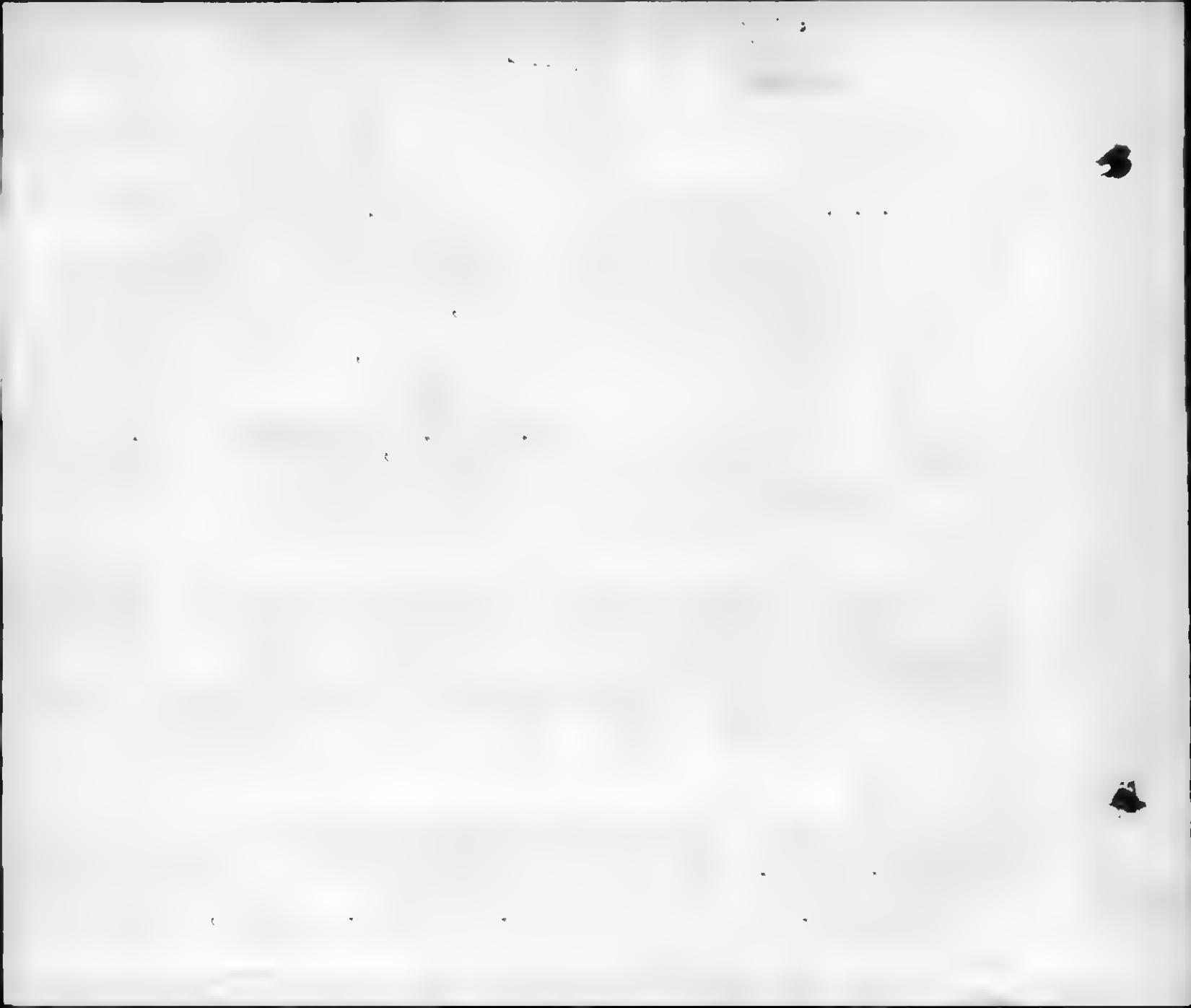
Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEATH: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH ■ COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) ■ STATE Maryland b COUNTY Wicomico							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O.A. Pen Gen Hospital							
3. NAME OF DECEASED (Type or print) JAMES		First JAMES	Middle WILLIAM	Last HARRISON	4. DATE OF DEATH OCTOBER 3rd 1958	Month Month	Doy Doy	Year Year	
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH May 12, 1881	9. AGE (In years last birthday) 77 yrs	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Deal Island, Maryland	12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME William Harrison		14. MOTHER'S MAIDEN NAME Margaret Cole		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or Unknown) Unk		16. SOCIAL SECURITY NO (If yes, give war or dates of service)		17. INFORMANT Mrs. Lula L. Harrison (Wife) 1000 E. Church St Salisbury, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		INTERVAL BETWEEN ONSET AND DEATH <i>subd</i>							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<i>Coronary Occlusion</i>							
DUE TO Conditions, if any, which gave rise to immediate cause (b)									
DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)		19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		DATE SIGNED <i>October 10 1958</i>							
ACTUAL SIGNATURE <i>Earl L. Royer</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		EXAMINER'S NAME (Type) Dr. Earl L. Royer			
22a. BURIAL CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 7th/58		22c. NAME OF CEMETERY OR CREMATORIUM Bivalve Meth. Church Cem.		22d. LOCATION (City, town, or county) Bivalve, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND		24a. REC'D BY REGISTRAR OCT 10 '58		24b. REGISTRAR'S SIGNATURE <i>Arthur & Kress</i>			

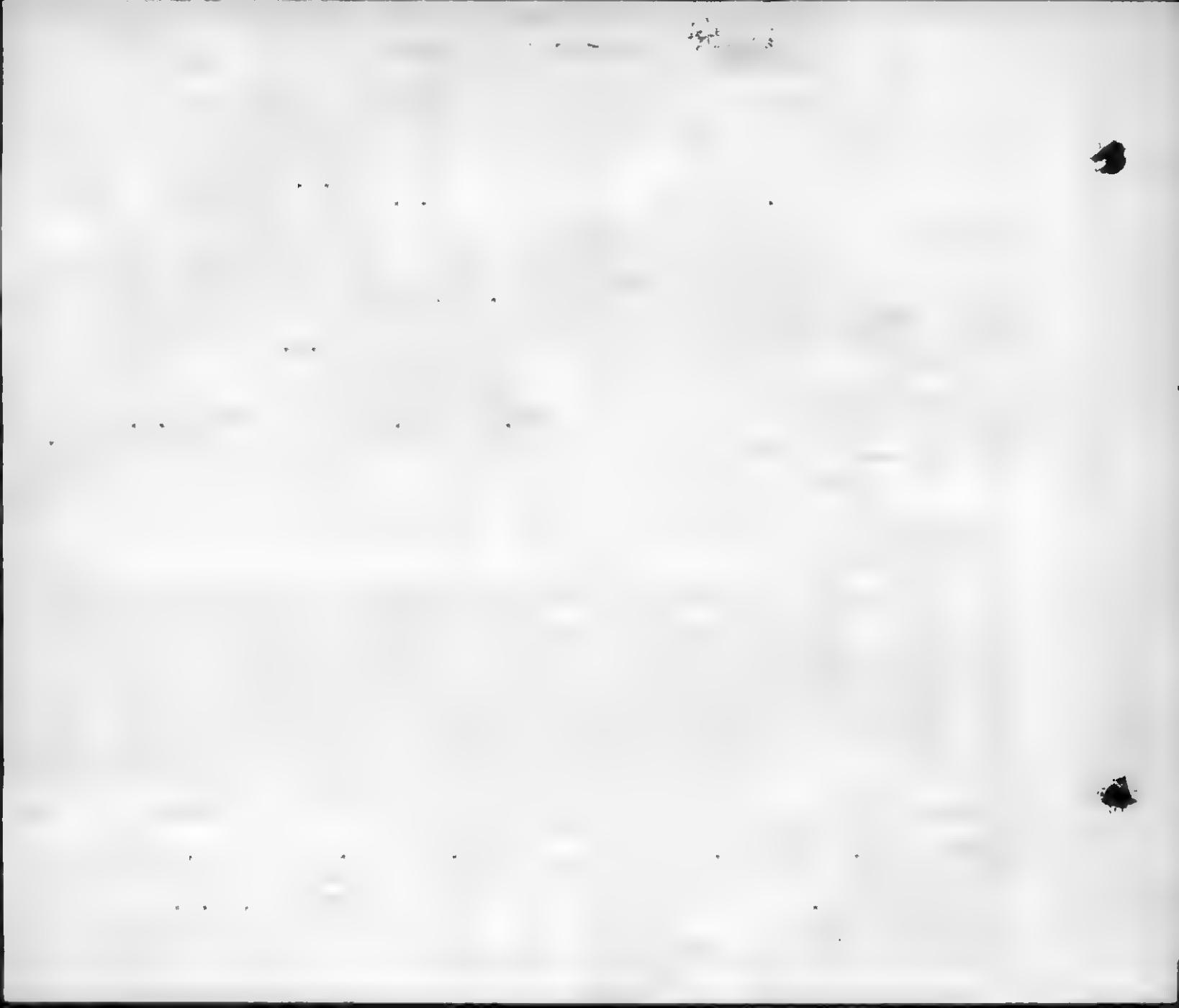


MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11867 CERTIFICATE OF DEATH

11869
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN lb		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Wicomico	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen Gen. Hospital						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			
3. NAME OF DECEASED (Type or print)		First BENJAMIN	Middle COMSTOCK	Lost HAWKINS	4. DATE OF DEATH OCTOBER 9th 19 58	Month OCTOBER	Day 9th	Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED	NEVER MARRIED DIVORCED	8. DATE OF BIRTH Jan. 28, 1899	9. AGE (In years to 1st birthday) 59 yrs.	10. IF UNDER 1 YEAR Months 9	11. IF UNDER 24 HRS Hours 11	12. IF ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner & Operator (Glass Shop)		10b. KIND OF BUSINESS OR INDUSTRY (If yes, give name or date of service)		11. BIRTHPLACE (State or foreign country) Woonsocket, R.I.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Benoni Hawkins		14. MOTHER'S MAIDEN NAME Elizabeth Mills							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unk		16. SOCIAL SECURITY NO.		17. INFORMANT Miss Miriam J. Hawkins (Sister) R.D.#(Ocean City Road) Route #50 Salisbury, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), slotting the under- lying cause last. (b) DUE TO (c)		Coronary Thrombosis		INTERVAL BETWEEN ONSET AND DEATH 24 hrs					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from _____, 1958, to 10-9, 1958, that I last saw the deceased alive on 10-9, 1958, and that death occurred at _____ M, from the causes and on the date stated above.							ADDRESS (Street, city or town, state)	DATE SIGNED October 10 1958	
ACTUAL SIGNATURE <i>Philip A. Insley</i>		M.D.							
PHYSICIAN'S NAME (Type) Dr. Philip A. Insley		116 E. Main St. Salisbury, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 13/1958		22c. NAME OF CEMETERY OR CREMATORIUM Oak Hill Cemetery		22d. LOCATION (City, town, or county) Woonsocket, R.I. (State)			
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND		24a. REC'D BY REGISTRAR DATE OCT 14 '58		24b. REGISTRAR'S SIGNATURE <i>Linus S. Krause</i>			



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be retained for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11868 CERTIFICATE OF DEATH

11870

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>MARYLAND</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MARYLAND</i> b. COUNTY <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>MARDELLA</i>	c. LENGTH OF STAY IN 1b <i>407 1/2</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>MARDELLA</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>MARDELLA</i>		d. STREET ADDRESS <i>308 1/2</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>EDWIT MAY</i>	First	Middle	Last
4. DATE OF DEATH <i>October 14 1958</i>	Month	Day	Year
5. SEX <i>MALE</i>	6. COLOR OR RACE <i>BLKED</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>FEB. 14, 1912</i>
9. AGE (in years lost birthday) <i>46 yrs</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Days <i>0</i>	12. IF UNDER 24 HRS Hours <i>0</i>
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSE WORK</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>HOME</i>	11. BIRTHPLACE (State or foreign country) <i>WICOMICO CO. MD.</i>	12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>
13. FATHER'S NAME <i>THOMAS BYRD</i>	14. MOTHER'S MAIDEN NAME <i>ETHEL WALLER</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>220-09-8918</i>	17. INFORMANT <i>ALBERT HAYMAN, MARDELLA SPRINGS, MD</i>	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO CHRONIC NEPHRITIS (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DISEASE Years			
			INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>10/11/1958</i> to <i>10/14/1958</i> that I last saw the deceased alive on <i>10/13/1958</i> , and that death occurred at <i>10/14/1958</i> A.M., from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED <i>10-14-58</i>			
ACTUAL SIGNATURE <i>J. J. FRAMPTON</i>	PHYSICIAN'S NAME (Type) <i>J. J. FRAMPTON & SON</i>		22. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>
22b. DATE THEREOF <i>OCT. 19, 1958</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>OLD CHURCH CEMETERY</i>	22d. LOCATION (City, town, or county) <i>MARDELLA SPRINGS, MD.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. J. FRAMPTON & SON, FEDERALSBURG, MD.</i>	ADDRESS	24a. REC'D BY REGISTRAR DATE <i>OCT 17 1958</i>	24b. REGISTRAR'S SIGNATURE <i>J. J. FRAMPTON & SON, FEDERALSBURG, MD.</i>



1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11871

Reg. Dist. No.

1. PLACE OF DEATH **11869** 2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission)
a. COUNTY **Wicomico** b. STATE **Maryland** c. COUNTY **Wicomico**

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Salisbury

c. LENGTH OF STAY IN lb

MARYLAND

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Salisbury

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Penna. Railroad Bridge & E. Main St

d. STREET ADDRESS

922 Johnson St

Is the deceased
ON A FARM?
YES NO

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

Month
OCTOBER

Doy
5th

Year
1958

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

Sept. 21, 1893

9. AGE (in years
last birthday)

65

10. IF UNDER 1 YEAR

0

11. IF UNDER 24 HRS

14

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laborer-Retired

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

Somerset Co. Maryland

U S A

13. FATHER'S NAME

Thomas Hitch

14. MOTHER'S MAIDEN NAME

Annie Cantwell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 16. SOCIAL SECURITY NO.

Unk

16. SOCIAL SECURITY NO.

17. INFORMANT

**Mrs. Minnie Hitch (Wife) 922 Johnson St.
Salisbury, Maryland**

INTERVAL BETWEEN
ONSET AND DEATH

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY;
IMMEDIATE CAUSE (a)

over

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)
DUE TO
(c)

Hemorrhage

**Compound Fracture left orbit
& maxilla**

Sudden

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY
PERFORMED?

YES NO

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

Struck by train.

20c. TIME OF INJURY Month, Day, Year
Hour **10-5-1958**

20d. INJURY OCCURRED
White
Not white
at work
at work

20e. PLACE OF INJURY (Home, Farm,
factory, street, office, etc.)

20f. (City or town) **P.R.R. tracks** (County) **Salisbury** (State) **Wicomico Md.**

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type) **Dr. Earl L. Royer**

M.D. CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

October 6 1958

22a. BURIAL, CREMATION, DATE THEREOF
REMOVAL (Specify)
Burial **Oct. 8, 1958**

22c. NAME OF CEMETERY OR CREMATORIUM
Parsons Cemetery

22d. LOCATION (City, town, or county)
Salisbury, Maryland (State)

23. FUNERAL DIRECTOR'S SIGNATURE

HOLLOWAY & COMPANY SALISBURY MARYLAND

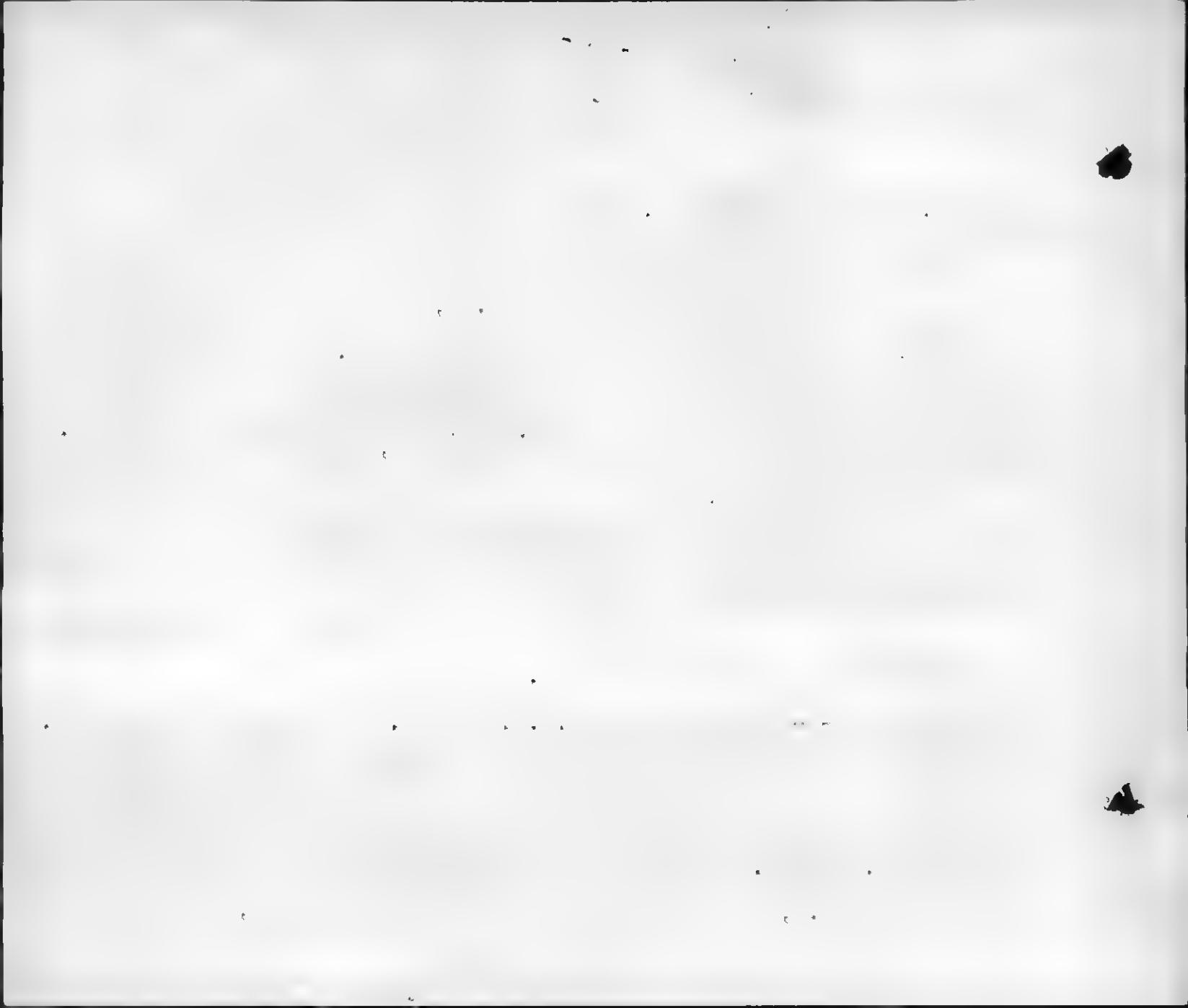
ADDRESS

24a. REC'D BY REGISTRAR
DATE **OCT 10 58**

24b. REGISTRAR'S SIGNATURE
Lewis S. France

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form M3. Page 1 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be given to a burial-trust permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours of death.

VS A15ME
SM 2/57



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11872

CERTIFICATE OF DEATH

Reg. Dist. No.

11870

1. PLACE OF DEATH a. COUNTY Wicomico		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		b. COUNTY Baltimore City	
c. LENGTH OF STAY IN lb 1 yr		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		d. STREET ADDRESS 1918 Herbert St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Ruth	Middle Elizabeth	Last Hood
4. DATE OF DEATH	Month October	Day 7	Year 1958
5. SEX Female	6. COLOR OR RACE Col.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/30/1907
9. AGE (in years last birthday) 51	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. Hrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Housework	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Samuel Larkins	14. MOTHER'S MAIDEN NAME Mary Lewis		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) Unk.	16. SOCIAL SECURITY NO. NONE	17. INFORMANT Hospital Records	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
Recurrent cerebral hemorrhage ? Hypertensive cardiovascular disease			
INTERVAL BETWEEN ONSET AND DEATH 7 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Sept. 16, 1957, to Oct. 7, 1958, that I last saw the deceased alive on Oct. 7, 1958, and that death occurred at 8:55A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Dr. V. Juerman, M.D. Deer's Head State Hospital Salisbury, Maryland DATE SIGNED 10/7/58			
ACTUAL SIGNATURE Dr. V. Juerman.		NAME (Type) V. Juerman, M. D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 10/12/58		22b. DATE THEREOF 10/12/58	
22c. NAME OF CEMETERY OR CREMATORIUM Pine Grove		22d. LOCATION (City, town, or county) White Hall Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph J. McAllister Salisbury, Md.		24a. REC'D BY REGISTRAR OCT 10 1958	
ADDRESS 1515 W. Calhoun St. Salisbury, Md.		24b. REGISTRAR'S SIGNATURE Clyde S. Krause	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

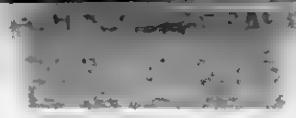
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

CERTIFICATE OF DEATH

11871 11873
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		b. COUNTY Wicomico	
c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen. Gen. Hospital		d. STREET ADDRESS 510 Ann St	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First BARBARA	Middle ANN	Last HORSEMAN
4. DATE OF DEATH	Month October	Day 6th	Year 1958
5. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> Baby DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH October 5, 1958	9. AGE (in years last birthday) 0 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Salisbury, Md.-Hospital	12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME George Carroll Horseman		14. MOTHER'S MAIDEN NAME Jo Ann Hearn	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO No	17. INFORMANT Mr. George C. Horseman (Father) 510 Ann St Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 16 d. c DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>atelectasis of both lungs, 1 day severe Respiratory</i>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour o. m. p. m.	Month, Doy, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Oct. 5, 1958</u> to <u>Oct. 6, 1958</u> , that I last saw the deceased alive on <u>Oct. 5, 1958</u> , and that death occurred at <u>2:40 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>J.V. Schler</i>	ADDRESS (Street, city or town, state) M.D. <i>Delmar, Md.</i>		DATE SIGNED <i>October 6, 1958</i>
PHYSICIAN'S NAME (Type) Dr. L.V. Schler		303 East Delmar, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct. 8, 1958	22c. NAME OF CEMETERY OR CREMATORIUM Laurel Hill Cemetery	22d. LOCATION (City, town, or county) Laurel, Delaware (State)
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND	24a. REC'D BY REGISTRAR DATE OCT 10 '58
			24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11877

11913

Item 9 Film 11-5-58 et

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Quantico		c. LENGTH OF STAY IN 1b 7 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First WINFIELD Middle Last HORSMAN		4. DATE OF DEATH Oct. 25 1958 Month Day Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/25/1877
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm labor	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John Horsman		14. MOTHER'S MAIDEN NAME Martha Bedsworth	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO World War #1	
17. INFORMANT Mrs William Couch, Quantico, Maryland		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause (b) DUE TO Generalized Arteriosclerosis.		INTERVAL BETWEEN ONSET AND DEATH 12 hours. 10 years.	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11 April 1947</u> to <u>25 Oct 1958</u> , that I last saw the deceased alive on <u>25 Oct 1958</u> , and that death occurred at <u>910 AM</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE Richard H. Saunders, M.D.		DATE SIGNED 10/27/58	
PHYSICIAN'S NAME (Type)		Nanticoke, Maryland 10/27/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 10/28/58	
22c. NAME OF CEMETERY OR CREMATORIUM Bivalve Cem.		22d. LOCATION (City, town, or county) Bivalve, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE C. D. Messick		ADDRESS Bivalve, Maryland	
24a. REC'D BY REGISTRAR Oct 31 '58		24b. REGISTRAR'S SIGNATURE August S. Evans	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the physician, page 3 should be detached for use as the burial/transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

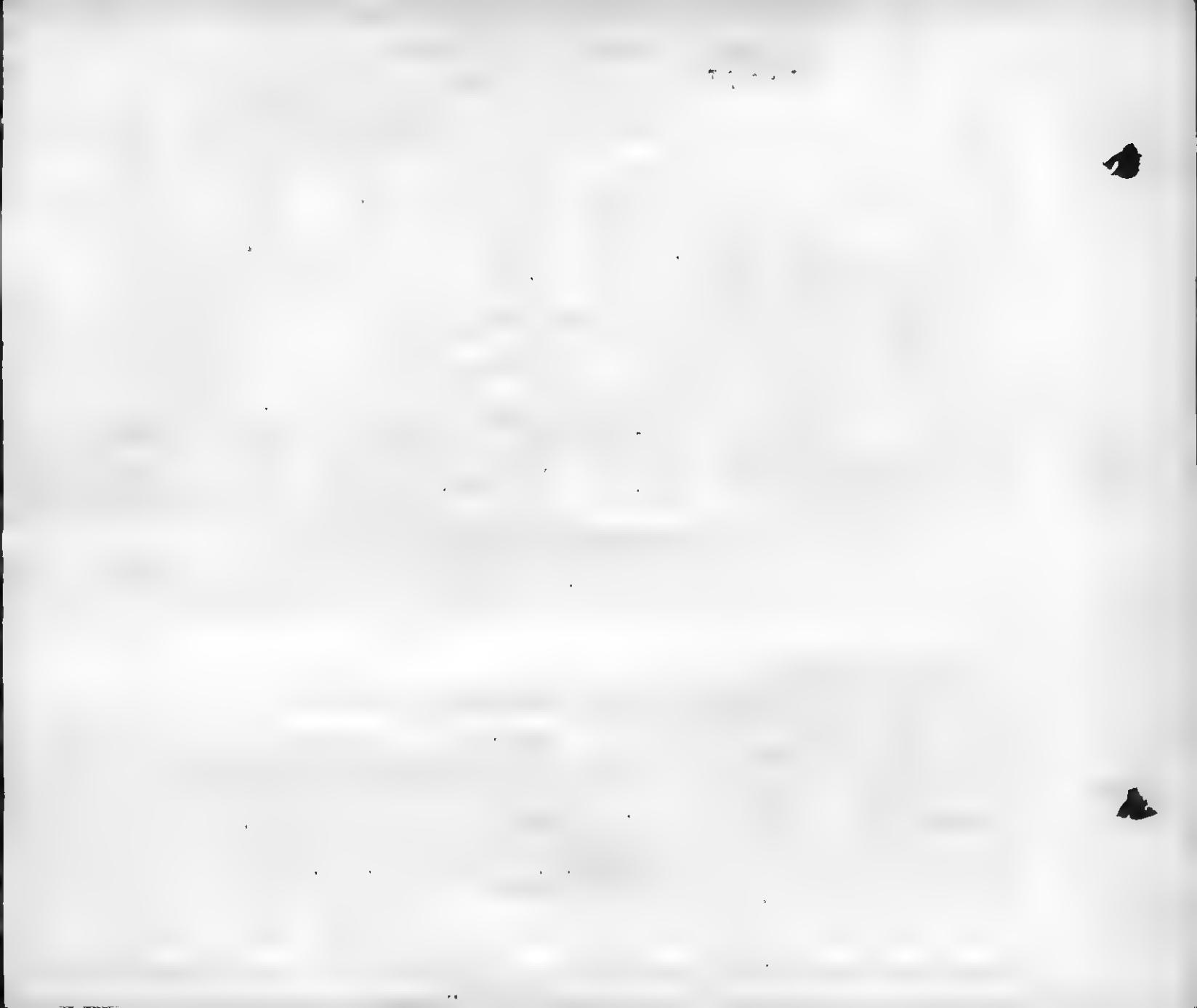
11874

11872

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Wicomico</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>		c. LENGTH OF STAY IN 1b <i>Hebron</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Peninsula General Hospital, Hebron Md.</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hebron</i>	
d. STREET ADDRESS <i>Peninsula General Hospital, Hebron Md.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>Annabelle</i>	Middle <i>Horsey</i>	Last <i>Oct. 18 1958</i>
4. DATE OF DEATH <i>Oct. 18 1958</i>	Month <i>Oct.</i>	Day <i>18</i>	Year <i>1958</i>
5. SEX <i>female</i>	6. COLOR OR RACE <i>col.</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11/30/ 1920</i>
9. AGE (In years last birthday) <i>37 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i>	11. IF UNDER 24 HRS. Hours <i>0</i> Min. <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>mill</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>mill</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Harlond</i>		14. MOTHER'S MAIDEN NAME <i>Julia Rider</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>219-05-3506</i>	
17. INFORMANT <i>Roland Horsey</i>		Address <i>Hebron Md. box 362</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Haemorrhage</i> DUE TO <i>123</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO <i>Eclampsic convulsions</i> (c) <i>Toxemia of Pregnancy</i> INTERVAL BETWEEN ONSET AND DEATH <i>2+ days</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>10/16 1958</i> to <i>10/18 1958</i> that I last saw the deceased alive on <i>10/18 1958</i> , and that death occurred at <i>10:15 A.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>ADDRESS (Street, city or town, state)</i> DATE SIGNED <i>10/22/58</i>			
ACTUAL SIGNATURE <i>Osborne Chris Tresser M.D.</i>			
PHYSICIAN'S NAME (Type) -			
22a. BUR. AL. CEMAT. ON. REMOVAL (Specify) <i>burial</i>	22b. DATE THEREOF <i>10/21/ 58</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Quantico</i>	22d. LOCATION (City, town, or county) (State) <i>Quantico Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Clinton F. Stewart</i>		ADDRESS <i>West Road Salisbury Md.</i>	24a. REC'D BY REGISTRAR DATE <i>OCT 24 '58</i>
24b. REGISTRAR'S SIGNATURE <i>Osborne S. Tresser</i>			



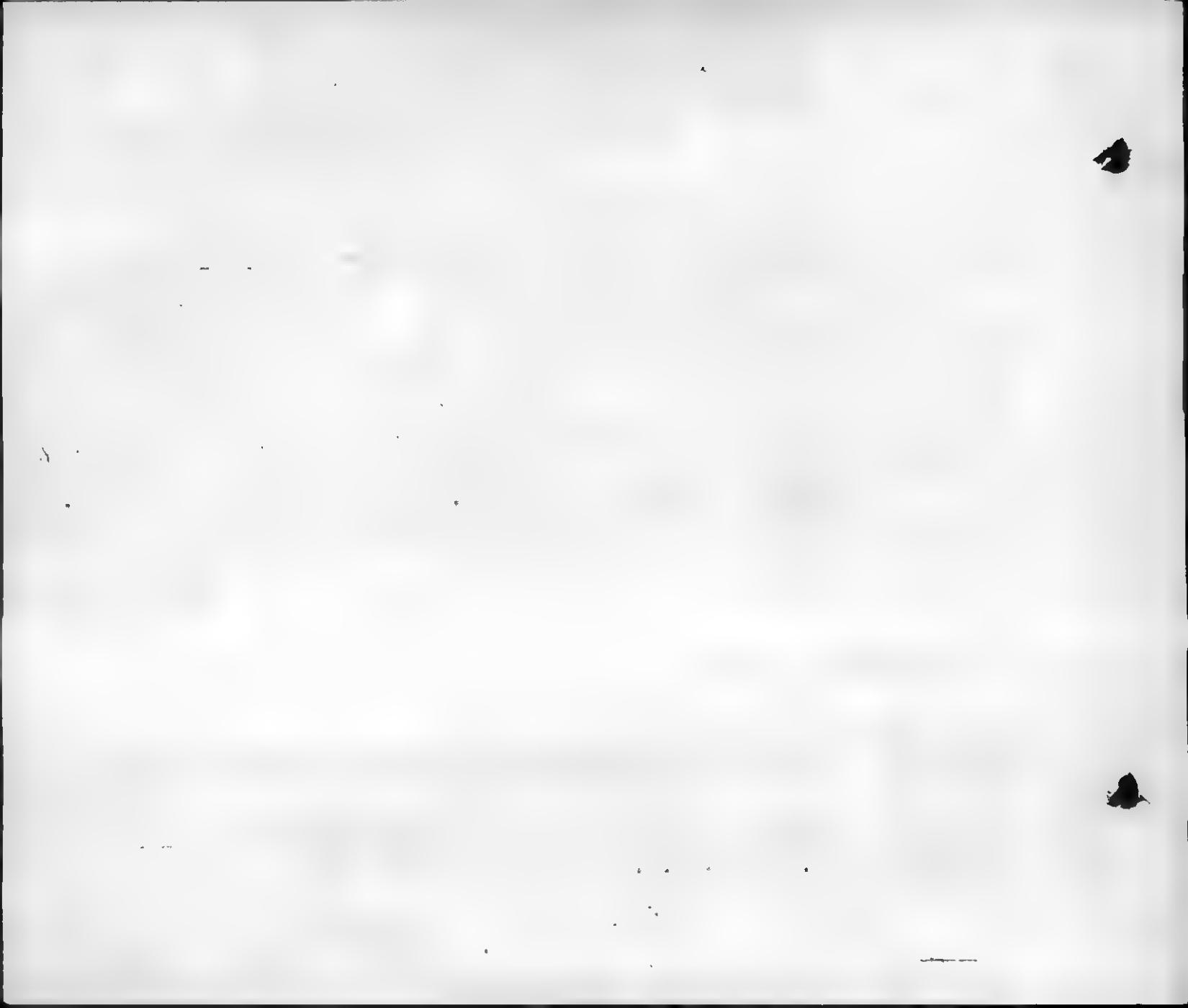
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11875
 Reg. Dist. No.

**FOR STATE
 HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please write the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PH3. Page 5 may be retained for 4 weeks. **TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Wicomico		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If within corporate limits, write RURAL and give nearest town) Fruitland		c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Home	
5. SEX F		6. COLOR OR RACE C	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH Sept 16-58	
9. AGE (in years last birthday) 1		10. DATE OF DEATH 10-31-58	
11. IF UNDER 1 YEAR Months 1 Days 0		12. IF UNDER 24 HRS Hours 0 Min 0	
13. FATHER'S NAME LEONARD. Horsey			
14. MOTHER'S MAIDEN NAME ESTHER A COLLINS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.			
17. INFORMANT LEONARD, Horsey			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho-pneumonia. DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (d) (d) (e) (f) (g) (h) (i) (j) (k) (l) (m) (n) (o) (p) (q) (r) (s) (t) (u) (v) (w) (x) (y) (z)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Net white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Earl L. Royer, M.D.</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Bur		22b. DATE THEREOF Nov 2-58	
22c. NAME OF CEMETERY OR CREMATORIUM Westover		22d. LOCATION (City, town, or county) (State) Westover, SOM MD	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Charles H. Ward Marion MD</i>		24a. REC'D BY REGISTRAR DATE NOV 5 '58	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11876

11873

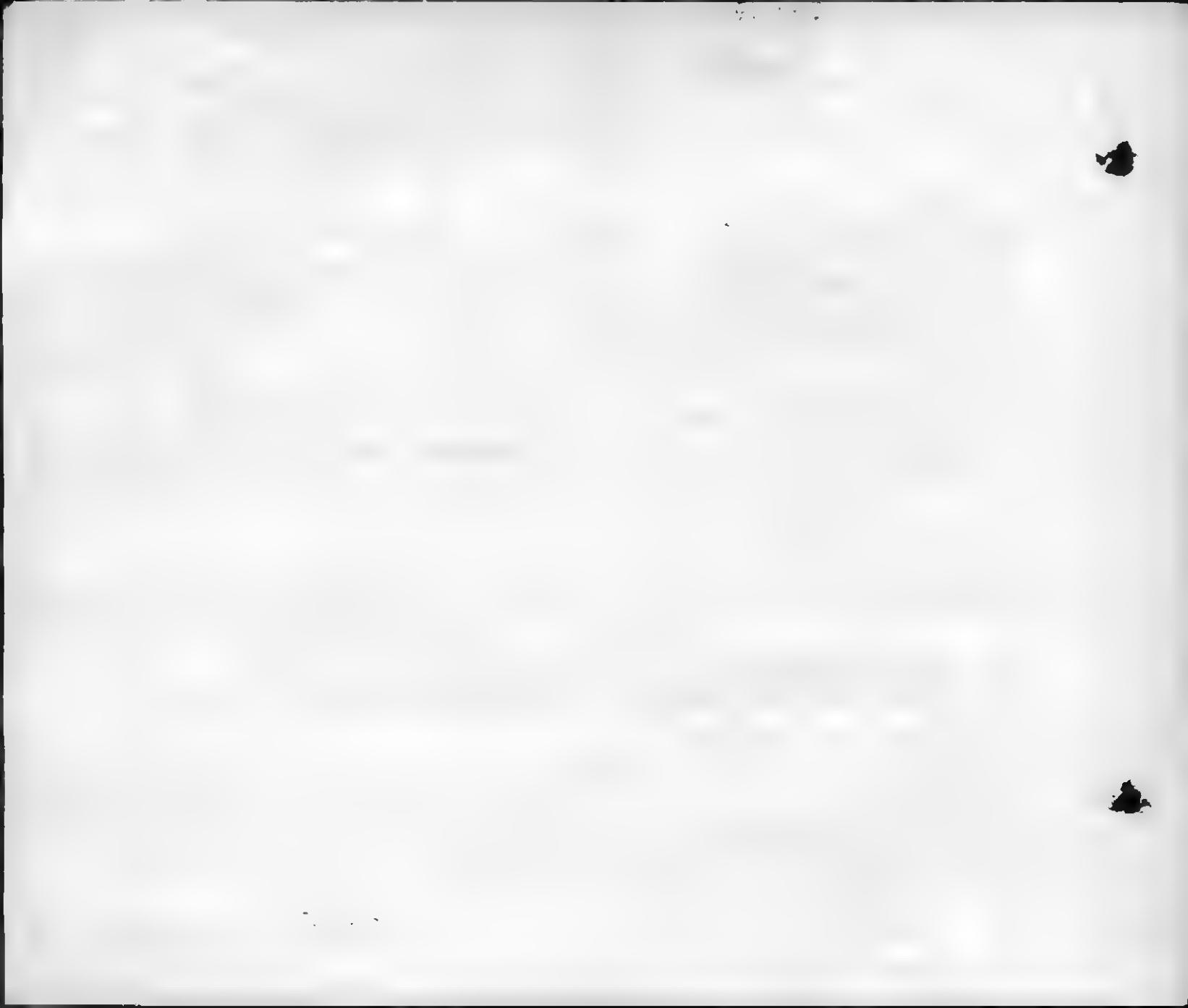
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WICOMICO		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland		b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fruitland		d. STREET ADDRESS Poplar St.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PENINSULA General HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) James		First	Middle	Last	4. DATE OF DEATH October 3, 1958	Month	Day	Year	
5. SEX Male		6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/16/1918	9. AGE (In years last birthday) 40	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. Hours 0	13. MIN. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salvor		10b. KIND OF BUSINESS OR INDUSTRY Salvor		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Granville Horsey		14. MOTHER'S MAIDEN NAME Frances Hale		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) Yes		16. SOCIAL SECURITY NO. 17. INFORMANT Rodosaica Horsey, fruitland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 590X		DUE TO Acute, fulminant nephritis		INTERVAL/BETWEEN ONSET AND DEATH 17 days					
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. inflammation		DUE TO inflammation							
DUE TO (b)									
(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Fruitland		(County) Fruitland	(State) Md.
21. I certify that I attended the deceased from Sept 20, 1958 to Oct 10-3, 1958 , that I last saw the deceased alive on Oct 3-58 , 1958, and that death occurred at 10 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE Lee L. Laundry									
ADDRESS (Street, city or town, state) Fruitland, Md. DATE SIGNED 10-3-58									
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 10/5/58		22c. NAME OF CEMETERY OR CREMATORIAL Mt. Calvary		22d. LOCATION (City, town, or county) Fruitland		(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Clinton Street Sales. 911d.		ADDRESS Clinton Street Sales. 911d.		24a. REC'D BY REGISTRAR DATE OCT 8 58		24b. REGISTRAR'S SIGNATURE John			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11878 CERTIFICATE OF DEATH

11878
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institut on Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Wicomico</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>		c. LENGTH OF STAY IN 1b <i>1 week</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>		d. STREET ADDRESS <i>Uninsured Hospital 408 W Main St.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Uninsured Hospital</i>				d. STREET ADDRESS <i>Salisbury</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>Howard</i>	Middle <i>Howard</i>	Last <i>Howard</i>	4. DATE OF DEATH <i>October 12 1958</i>	Month <i>Oct</i>	Day <i>12</i>	Year <i>1958</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>October 9 1958</i>	9. AGE (in years last birthday) yrs. <i>2</i>	10. IF UNDER 1 YEAR Months <i>2</i>	11. IF UNDER 24 HRS Hours <i>2</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>		11. BIRTHPLACE (State or foreign country) <i>None</i>		12. CITIZEN OF WHAT COUNTRY <i>None</i>	
13. FATHER'S NAME <i>Howard J. Berman</i>		14. MOTHER'S MAIDEN NAME <i>Barbara Moore</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO <i>None</i>		17. INFORMANT <i>None</i>		Address <i>None</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>763.5</i>		DUE TO <i>Respiratory Failure</i>				INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b). <i>Atelectasis</i>		DUE TO <i>Pneumonia</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) <i>No</i>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <i>None</i>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>10</i> p. m. <i>10</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>None</i>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Oct 9 1958</i> to <i>Oct 12 1958</i> , that I last saw the deceased alive on <i>Oct 12 1958</i> , and that death occurred at <i>None</i> , M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>None</i>		DATE SIGNED <i>10/12/58</i>					
ACTUAL SIGNATURE <i>William C. Morgan</i>		PHYSICIAN'S NAME (Type) <i>Medical Center</i>					
22a. BURIAL, CREMATION, REMOVAL, (Specify) <i>Burial</i>		22b. DATE THEREOF <i>10/16/58</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>None</i>		22d. LOCATION (City, town, or county) (State) <i>None</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Clinton C. Stewart</i>		ADDRESS <i>Clinton C. Stewart, 711 N. Main St., Salisbury, MD</i>		24a. REC'D BY REGISTRAR <i>None</i>		24b. REGISTRAR'S SIGNATURE <i>None</i>	
				DATE <i>OCT 20 58</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

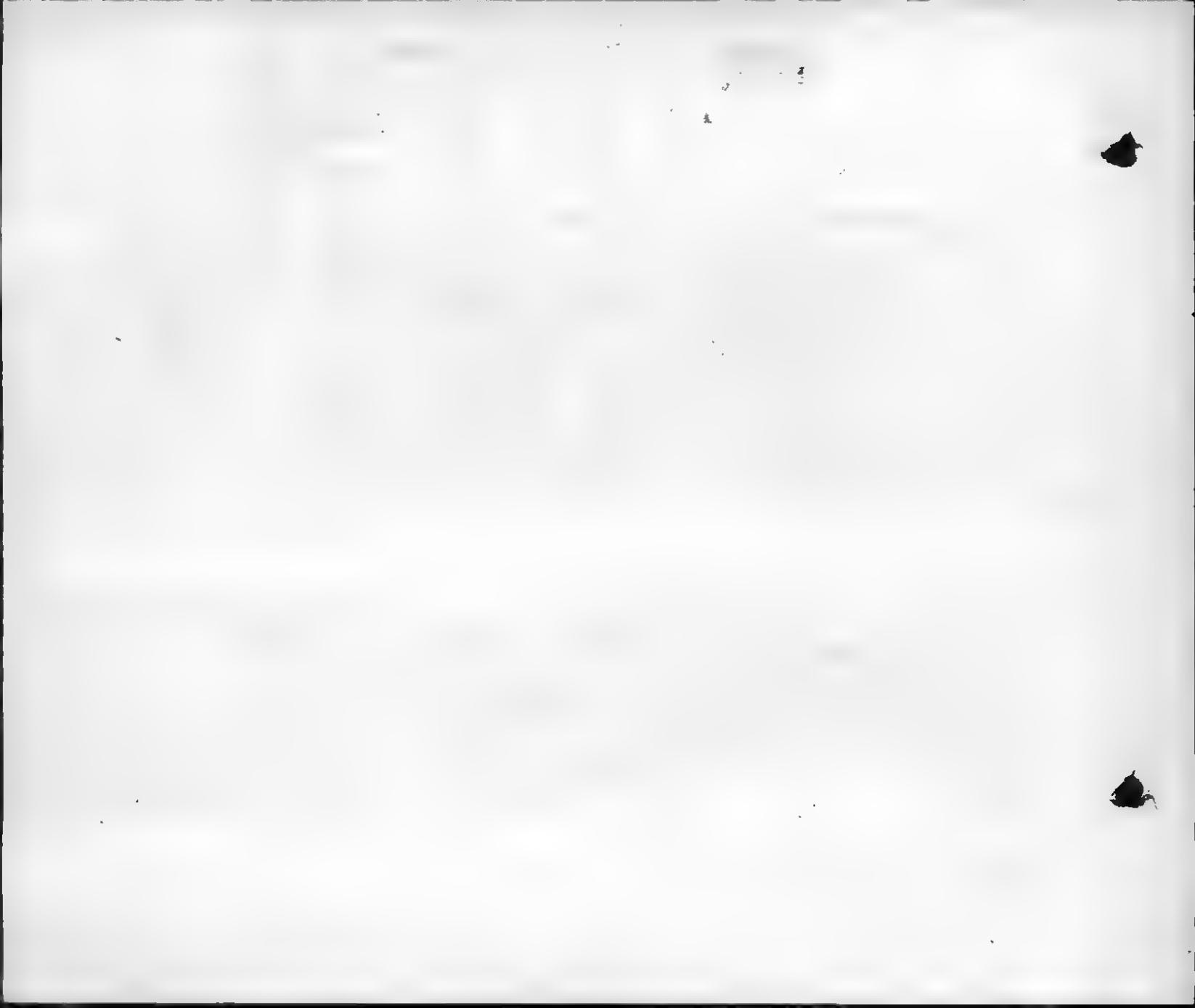
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the
 page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should
 be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11876 CERTIFICATE OF DEATH 11880

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		b. COUNTY Wicomico	
c. LENGTH OF STAY IN 1b 2 Wks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bivalve	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula General Hospital		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Lena	Middle -	Last Larmon
4. DATE OF DEATH October 21- 1958	Month	Day	Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/25/1885
9. AGE (In years last birthday) 77 yrs	10. USUAL OCCUPATION (Give kind of work done during most of working life, even retired) Housewife	11. KIND OF BUSINESS OR INDUSTRY Own Home	12. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME McHenry Robertson	14. MOTHER'S MAIDEN NAME Mary Lester Wilson	15. CITIZEN OF WHAT COUNTRY? U.S.	
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	17. SOCIAL SECURITY NO - - -	18. INFORMANT Milton Larmon	Address Salisbury, Md.
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)		20. INTERVAL BETWEEN ONSET AND DEATH 1 yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 10/21-1958 to 10/21-1958, that I last saw the deceased alive on 10/24-1958, and that death occurred at 1:30 P.M. from the causes and on the date stated above ADDRESS (Street, city or town, state) M.D. DATE SIGNED ACTUAL SIGNATURE H. A. Briele H. A. Briele			
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Bury	22b. DATE THEREOF 10/24/58	22c. NAME OF CEMETERY OR CREMATORIUM Bivalve Cem.	22d. LOCATION (City, town, or county) Bivalve, Md. (State)
23. FUNERAL DIRECTOR'S SIGNATURE C. D. Mesovich, Bivalve, Md.	ADDRESS	24a. REC'D BY REGISTRAR DATE 28 '58	24b. REGISTRAR'S SIGNATURE C. D. Mesovich



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11877

CERTIFICATE OF DEATH

11881

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>MARYLAND</i>		b. COUNTY <i>Wicomico</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>		c. LENGTH OF STAY IN lb <i>4 wks.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Whaleyville</i>		d. STREET ADDRESS <i>Route #1</i>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Peninsula General Hospital</i>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print)	First <i>Carney</i>	Middle <i>Leonard</i>	Last <i>Carney</i>	4. DATE OF DEATH <i>October 8 - 1958</i>	Month <i>October</i>	Day <i>8</i>	Year <i>1958</i>				
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <i>April 15, 1901</i>	8. AGE (In years last birthday) <i>57 yrs.</i>	9. IF UNDER 1 YEAR Months <i>57</i>	10. IF UNDER 24 HRS Hours <i>0</i>	11. IF UNDER 24 HRS Min. <i>0</i>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>FARMER</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farming</i>		11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>					
13. FATHER'S NAME <i>FRANK LEONARD</i>		14. MOTHER'S MARRIED NAME <i>Aelanta Timmons</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>NONE</i>					
17. INFORMANT <i>Mrs. Gertrude Leonard-Waleyville, Md</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>222X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Arteriosclerosis with</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Hour a. m p. m 19		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from alive on and that death occurred at ADDRESS (Street, city or town, state) DATE SIGNED		21. I certify that I attended the deceased from <i>9/10/1958</i> to <i>10/16/1958</i> that I last saw the deceased alive on <i>10/16/1958</i> and that death occurred at <i>4:58 P.M.</i> from the causes and on the date stated above. <i>Salisbury, Md.</i> <i>10/16/1958</i>		22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>10-11-58</i>		22c. NAME OF CEMETERY OR CEMETORY <i>St. Peter's Cemetery</i>		22d. LOCATION (City, town, or county) <i>N. Newark, Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J.F. Stewart Funeral Home, Salisbury, Md</i>		ADDRESS <i>J.F. Stewart Funeral Home, Salisbury, Md</i>		24a. REC'D BY REGISTRAR DATE <i>OCT 15 58</i>		24b. REGISTRAR'S SIGNATURE <i>Wm. J. Thorne</i>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the attending physician. After this certificate has been signed by the attending physician and completely filled in by the attending physician, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

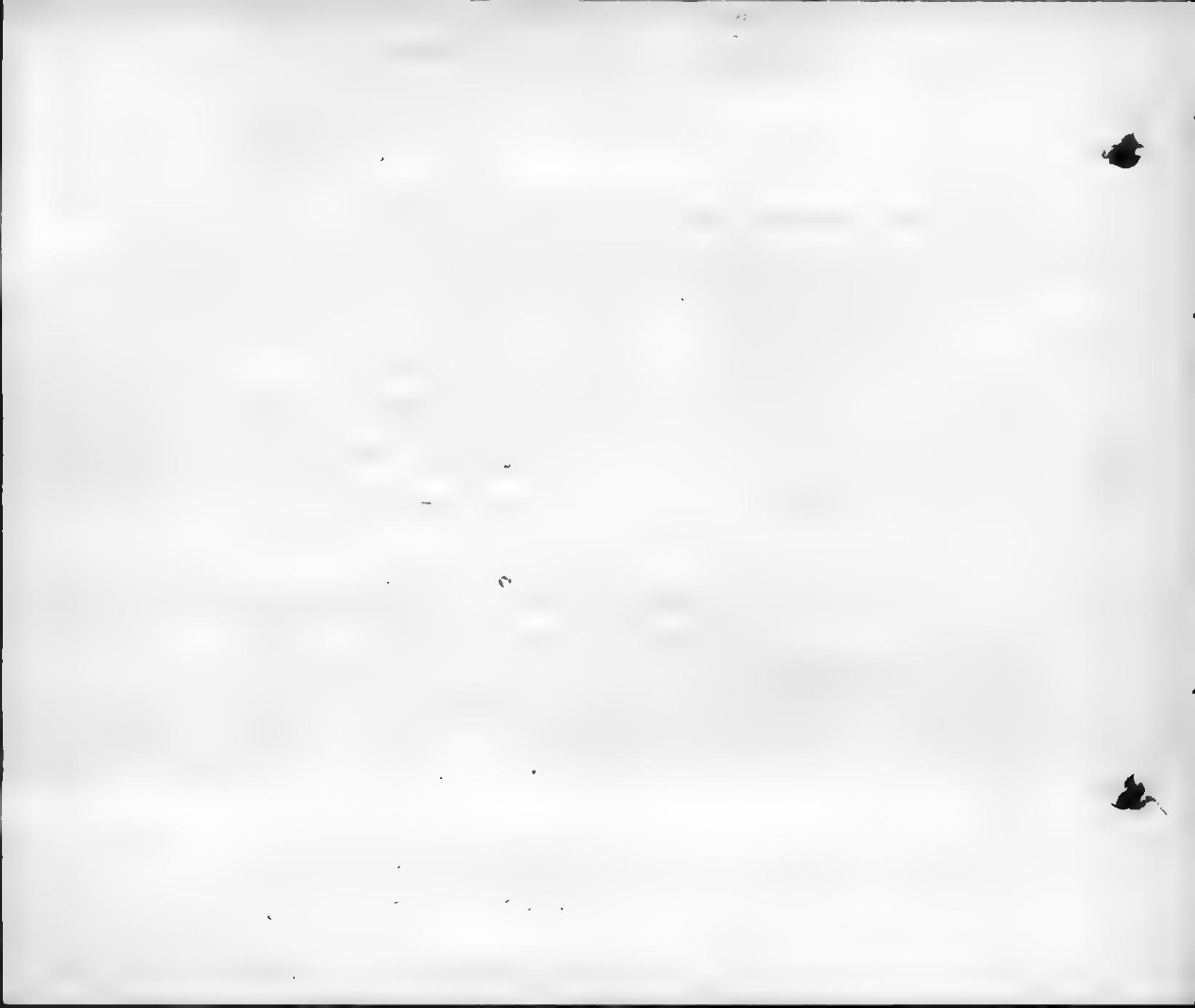
11878

CERTIFICATE OF DEATH

11882

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>VIRGINIA</i>		b. COUNTY <i>Accomack</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>		c. LENGTH OF STAY IN 1b RURAL and give nearest town <i>Accomack</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Maplesville 83X</i>		d. STREET ADDRESS <i>Maplesville 83X</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Peninsula General Hospital</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>Clearville</i>		First	Middle	Lost	4. DATE OF DEATH <i>Littleton</i>	Month	Day	Year
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb. 8, 1882</i>	9. AGE (In years lost birthday) <i>76 yrs</i>	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>		
13. FATHER'S NAME <i>FRANK LITTLETON</i>		14. MOTHER'S MAIDEN NAME <i>JANE TATEM</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mrs. Ruby LASSON, Rr2 Newcastle</i>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Subarachnoid Hemorrhage</i>		DUE TO <i>Arteriosclerotic vascular Disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i>				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>Arteriosclerotic vascular Disease</i>		DUE TO <i>Hypertensive Cardiovascular Disease</i>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Pine Bluff Road</i>		20f. (City or town) <i>Salisbury, Md.</i>		(County) (State)
21. I certify that I attended the deceased from <i>Oct 13, 1958</i> to <i>Oct 16, 1958</i> , that I last saw the deceased alive on <i>Oct 16, 1958</i> , and that death occurred at <i>12:50 A.M.</i> from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <i>Pine Bluff Road</i>		DATE SIGNED <i>10/16/58</i>		
ACTUAL SIGNATURE <i>Thomas C. Hill, M.D.</i>								
PHYSICIAN'S NAME (Type) <i>Thomas C. Hill, M.D.</i>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial 10/19/58</i>		22b. DATE THEREOF <i>10/19/58</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Parksley</i>		22d. LOCATION (City, town, or county) <i>Parksley, Va.</i>		(State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>Henry M. Johnson, Parksley, Va.</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE <i>OCT 24 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Evans</i>		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11883

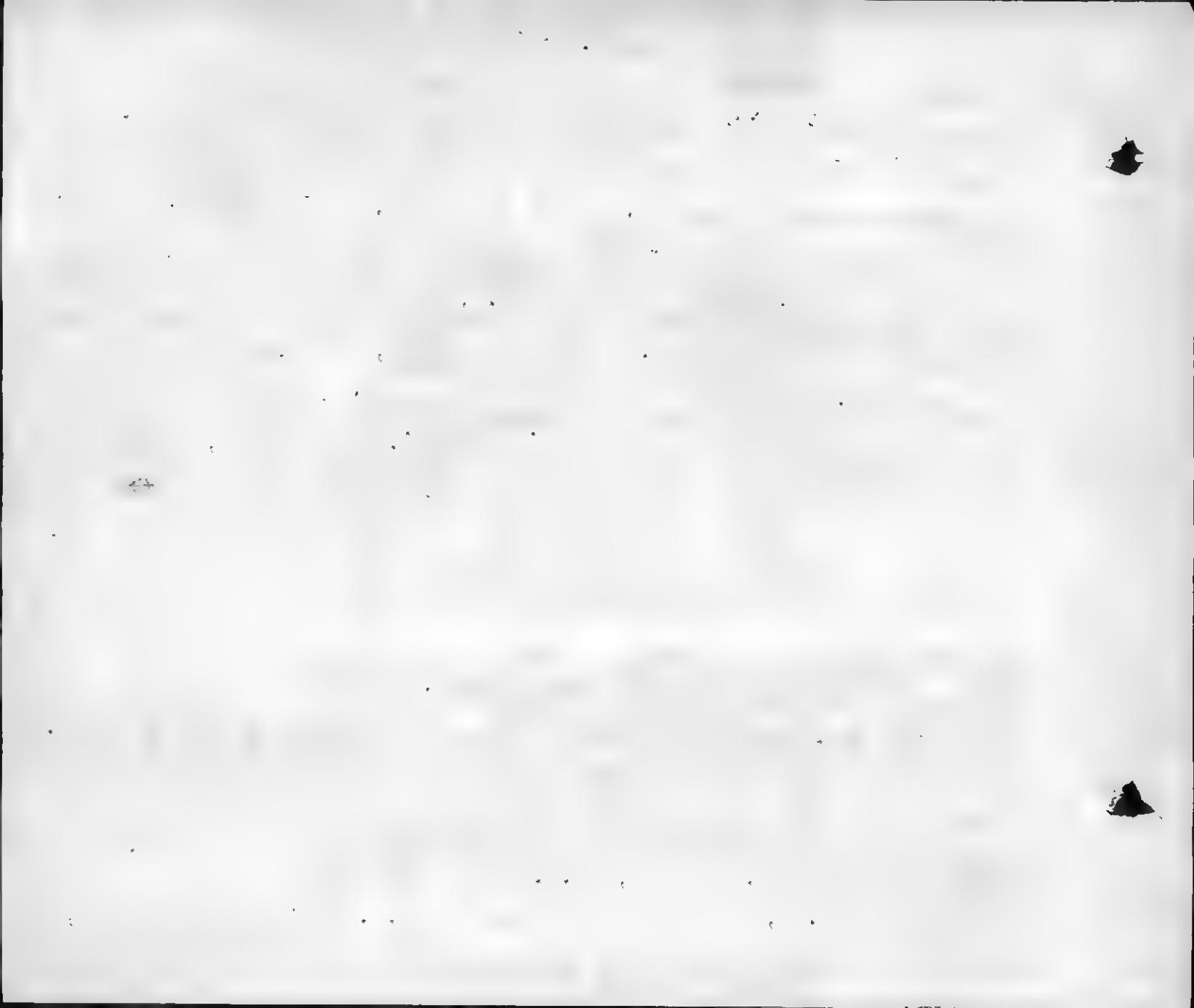
Reg. Dist. No.

11879

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Wicomico		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN lb years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
3. NAME OF DECEASED (Type or print) Ernest		First louis	Middle Maddux
4. DATE OF DEATH Month October		Day 15	Year 1958
S. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 1, 1878
9. AGE (In years last birthday) 80	10. IF UNDER 1 YEAR Months 80	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Employee	10b. KIND OF BUSINESS OR INDUSTRY Ice Co.	11. BIRTHPLACE (State or foreign country) Salisbury, Maryland	12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME William B. Maddux	14. MOTHER'S MAIDEN NAME Virginia McCallister	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. 137-10-0000		17. INFORMANT Mrs. Bessie P. Maddux (Wife)	18. ADDRESS 712 Goldsborough St. Salisbury, Maryland
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 702.0			
DUE TO Fracture of Vertebrae and right 9th Rib			
INTERVAL BETWEEN ONSET AND DEATH 1 day			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)			
DUE TO Acute Congestive Cardiac Failure			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
DUE TO (c)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fall from tree at home.	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 11 a.m.)ct. 15		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home
20f. (City or town) Salisbury		(County) Wicomico	(State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Kendrick Mc Cullough</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) Kendrick Mc Cullough	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
	DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct. 17, 1958	22c. NAME OF CEMETERY OR CREMATORIAL Bethel Cemetery	22d. LOCATION (City, town, or county) R.D. # (Walston) Salisbury, Md.
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY	ADDRESS SALISBURY MARYLAND	24a. REC'D BY REGISTRAR OCT 20 '58	24b. REGISTRAR'S SIGNATURE <i>John S. Kraus</i>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

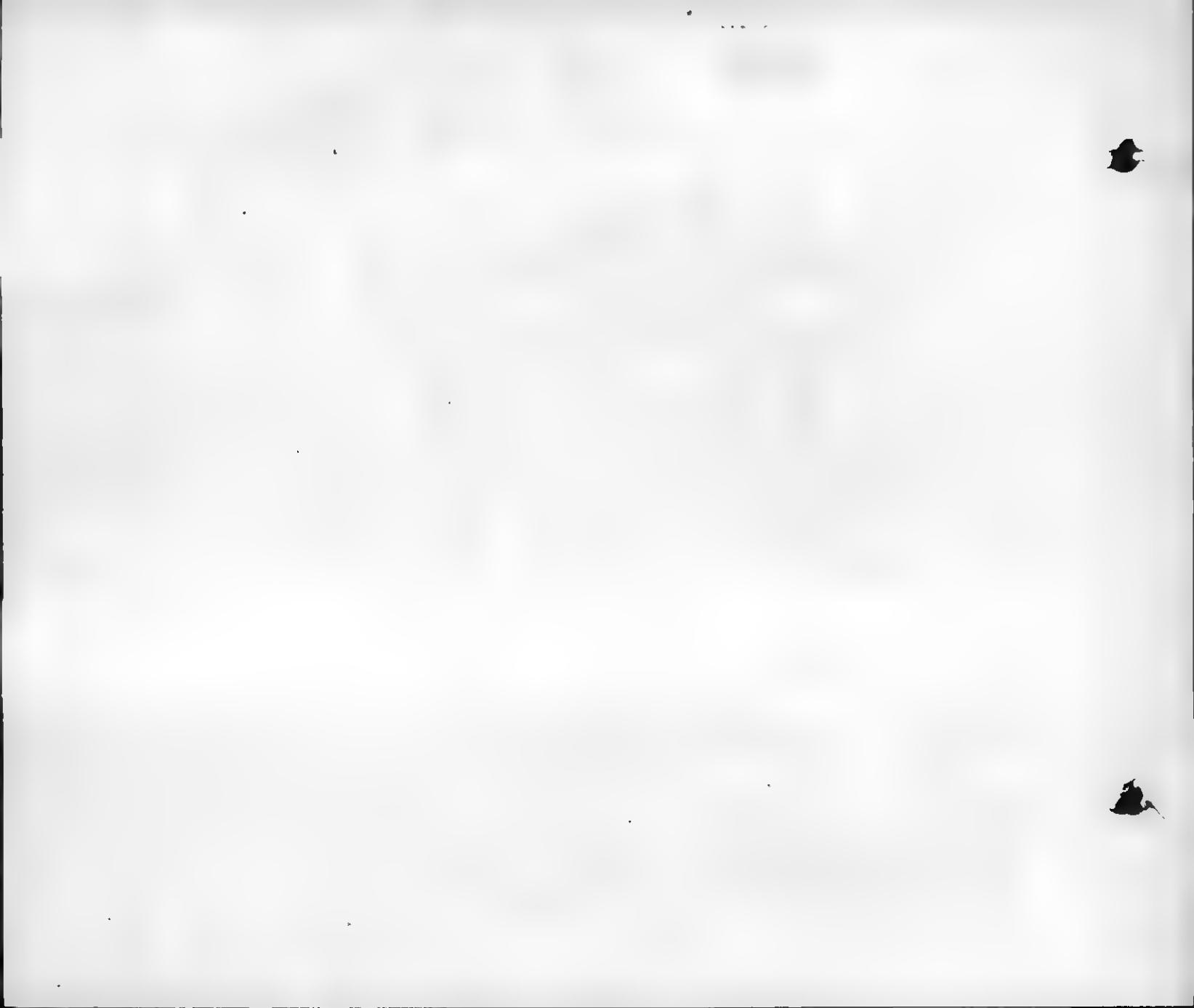
11880

CERTIFICATE OF DEATH

11884

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY		b. COUNTY Wicomico	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 12 SALISBURY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula General Hospital		d. STREET ADDRESS 1 Bond STREET	
3. NAME OF DECEASED (Type or print) IRMA B. MASON		4. DATE OF DEATH October 5, 1958	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>
8. DATE OF BIRTH July 16, 1906		9. AGE (In years last birthday) 52 yrs	10. IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BOOKKEEPING SERVICE		10b. KIND OF BUSINESS OR INDUSTRY Bookkeeper	11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME WILLIAM C. BREWINGTON	
14. MOTHER'S MAIDEN NAME Isadora Washburn		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) —	
16. SOCIAL SECURITY NO. —		17. INFORMANT Elizabeth Ann Lynch, Pompano Beach, Fla.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Wide spread metastatic carcinoma		INTERVAL BETWEEN ONSET AND DEATH months	
17a DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Adenocarcinoma of l. breast.		17b DUE TO (c) 2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/3/1958 to 10/5/1958 , that I last saw the deceased alive on 10/3/1958 , and that death occurred at 10 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>J. H. Morris</i>		ADDRESS (Street, city or town, state) —	
PHYSICIAN'S NAME (Type) —		DATE SIGNED —	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/7/1958	
22c. NAME OF CEMETERY OR CREMATORIAL Wicomico Mem. Park		22d. LOCATION (City, town, or county) Salisbury	
23. FUNERAL DIRECTOR'S SIGNATURE Thomas T. Walker		24a. REC'D BY REGISTRAR DATE OCT P '58	
ADDRESS Salisbury, Md.		24b. REGISTRAR'S SIGNATURE —	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11885

Reg. Dist. No.

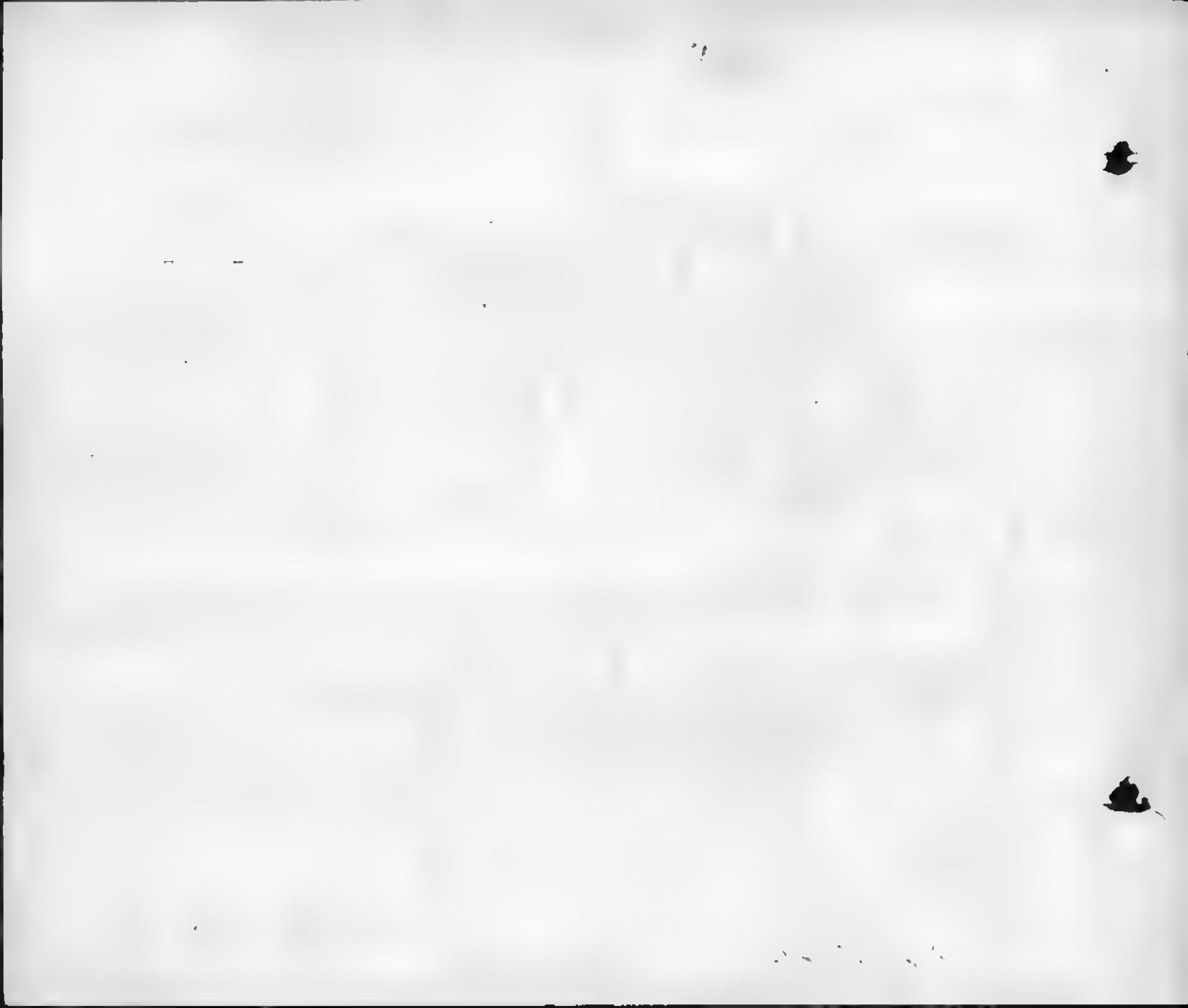
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.

TO FUNERAL DIRECTOR: OR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

11915

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Willards Wicomico				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Willards		c. LENGTH OF STAY IN 1b Willards		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Willards		d. STREET ADDRESS		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)								
e. IS MEDIUM ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
3. NAME OF DECEASED (Type or print) Robert Gordon McDonald		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Dec. 14, 1906	9. AGE (In years last birthday) 51 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) Credit Manager				10b. KIND OF BUSINESS OR INDUSTRY Accounting		11. BIRTHPLACE (State or foreign country) Pennsylvania		
13. FATHER'S NAME John A. Mc Donald				14. MOTHER'S MAIDEN NAME Sarah Picard				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) World #2		16. SOCIAL SECURITY NO 112-07-6023		17. INFORMANT Mrs. Rosalia McDonald Willards Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carbon Monoxide Poisoning 973.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) lay on ground behind car exhaust DUE TO (c)								
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) lay on ground behind car exhaust						
20c. TIME OF INJURY Hour — o. m. — p. m.	Month, Day, Year 10-4 1958	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) Willards	(County) Wicomico	(State) Md.		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>Earl L. Royer</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							DATE SIGNED 10-7-58
EXAMINER'S NAME (Type) Earl L. Royer	22b. DATE THEREOF 10/8/58							
22a. BURIAL, CREMATION IF BURIED, SPECIFY	22c. NAME OF CEMETERY OR CREMATORIUM Farlows							
22d. LOCATION (City, town, or county) Pittsville, Md.	(State)							
23. FUNERAL DIRECTOR'S SIGNATURE Peter Whaley	24a. REC'D BY REGISTRAR DATE OCT 10 1958							
ADDRESS Lillymelle Rd	24b. REGISTRAR'S SIGNATURE John K. Kuebler							



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11886

11881

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 2 yrs. 3 mo.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Milton	Middle -	Last Morris
4. DATE OF DEATH	Month October	Day 29th, 19	Year 58
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 7, 1876
9. AGE (In years lost birthday) 82 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ---	10b. KIND OF BUSINESS OR INDUSTRY ---	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Frances Morris	14. MOTHER'S MAIDEN NAME Martha Hurst	Address Deer's Head State Hospital Records, Salisbury, Md.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or No, or Unknown) Unk.	16. SOCIAL SECURITY NO ---	17. INFORMANT	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH Years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Ca. of Prostate			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 30, 1956, to October 29, 1958, at last saw the deceased alive on October 29, 1958, and that death occurred at 3:38 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. Deer's Head State Hospital 10/29/58 DATE SIGNED			
ACTUAL SIGNATURE L. V. Maldve, M. D.		PHYSICIAN'S NAME (Type) Salisbury, Maryland	
22a. BURIAL, CREMATION REMOVAL & CASKET REMOVAL & CASKET	22b. DATE THEREOF 10/29/58	22c. NAME OF CEMETERY OR CREMATORIUM East New Market	22d. LOCATION (City, town, or county) East New Market, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Kelly, Maldve, L. V. East New Market	ADDRESS East New Market	24a. REGISTRY & REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE C. L. Maldve

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11882

CERTIFICATE OF DEATH

11887

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		b. COUNTY Wicomico	
c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury - Rural	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula General Hospital		d. STREET ADDRESS West Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First	Middle	Last
4. DATE OF DEATH	Month	Day	Year
5. SEX Female	6. COLOR OR RACE bl.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 8, 1958
9. AGE (in years from birthday) yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours
13. FATHER'S NAME Albert H. Mumford	14. MOTHER'S MAIDEN NAME Pearl Dashield		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Albert H. Mumford, Salisbury, Md., R.F.D.	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO Pneumonia (c)			
INTERVAL BETWEEN ONSET AND DEATH			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, 19____, M, from the causes and on the date stated above ADDRESS (Street, city or town, state) _____ DATE SIGNED _____	William C. Morgan, M.D.		10-8-1958
ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) William C. Morgan		22d. LOCATION (City, town, or county) (State) Mardela Springs, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct. 10, 1958	22c. NAME OF CEMETERY OR CREMATORIAL Old Church Cemetery	22d. LOCATION (City, town, or county) (State) Mardela Springs, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE J. J. Frampton and Son, Federalsburg, Maryland	ADDRESS J. J. Frampton and Son, Federalsburg, Maryland	24a. REC'D BY REGISTRAR DAN 14 1958	24b. REGISTRAR'S SIGNATURE Arthur S. Kline



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11883

CERTIFICATE OF DEATH

Reg. Dist. No.

11888

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page **1**
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Wicomico</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town <i>Salisbury</i>		c. LENGTH OF STAY IN 1b <i>Life</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Salisbury - Rural</i>		d. STREET ADDRESS <i>West Road</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Peninsula General Hospital</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First <i>Merle</i>	Middle <i>El</i>	Losi <i>Maryland</i>	4. DATE OF DEATH <i>October 8, 1958</i>	Month <i>October</i>	Day <i>8</i>	Year <i>1958</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>October 8, 1958</i>		9. AGE (in years lost birthday) yrs. <i>0</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Days <i>0</i>	12. Hours <i>10</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Salisbury, Maryland</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>		
13. FATHER'S NAME <i>Albert H. Mumford</i>				14. MOTHER'S MAIDEN NAME <i>Pearl Dashield</i>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) <i>No</i>		16. SOCIAL SECURITY NO <i>None</i>		17. INFORMANT <i>Albert H. Mumford, Salisbury, Maryland</i>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>762.5</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Respiratory Failure</i> <i>Obstructive</i> INTERVAL BETWEEN ONSET AND DEATH								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <i>10-8-58</i> to <i>10-8-58</i> , that I last saw the deceased alive on <i>10-8-58</i> , and that death occurred at <i>Salisbury, Maryland</i> , from the causes and on the date stated above ADDRESS (Street, city or town, state) <i>Salisbury, Maryland</i> DATE SIGNED <i>10-8-1958</i>								
ACTUAL SIGNATURE <i>William C. Morgan</i> M.D.								
PHYSICIAN'S NAME (Type)		William C. Morgan						
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Oct. 10, 1958</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Old Church Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Mardela Springs, Maryland</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>J.J. Frampton and Son, Federalsburg, Maryland</i>		ADDRESS <i>J.J. Frampton and Son, Federalsburg, Maryland</i>		24a. REC'D BY REGISTRAR DATE <i>Oct 14 '58</i>		24b. REGISTRAR'S SIGNATURE <i>C. J. C. 14 '58</i>		

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11884

CERTIFICATE OF DEATH

11889

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		b. COUNTY Wicomico	
c. LENGTH OF STAY IN 1b RURAL and give nearest town Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen. Gen. Hospital		d. STREET ADDRESS 224 Maryland Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ROSE	First MIDDLE MCGAINTY	Last MUNDT	4. DATE OF DEATH OCTOBER 16th 1958
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 7th, 1888
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 10 Days 9 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work at Home		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Ireland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Patrick McGainty		14. MOTHER'S MAIDEN NAME Bridget Dunnion	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) No		16. SOCIAL SECURITY NO (If yes, give name or date of service) Mr. James H. Mundt (Son) R.D. # 2 Preston, Md.	
17. INFORMANT Mr. James H. Mundt (Son) R.D. # 2 Preston, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 330X DUE TO Subarachnoid Hemorrhage	
		INTERVAL BETWEEN ONSET AND DEATH 1 day	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Myocardial Insufficiency: Coronary Artery Heart Disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/1/01, 1953, to 10/16/1, 1958, that I last saw the deceased alive on Oct. 16, 1953, and that death occurred at 4:45 P.M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Dr. David J. Gilmore, M.D., Medical Center, Salisbury, October 18, 1958	
ACTUAL SIGNATURE Dr. David J. Gilmore PHYSICIAN'S NAME (Type) Dr. Wilber Ellis Jr.		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 20, 1958	
22c. NAME OF CEMETERY OR CREMATORIAL Spring Hill Cem. (New Section)		22d. LOCATION (City, town, or county) Easton, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND	
		24a. REC'D BY REGISTRAR DATE OCT 20 '58	
		24b. REGISTRAR'S SIGNATURE John S. Kraus	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

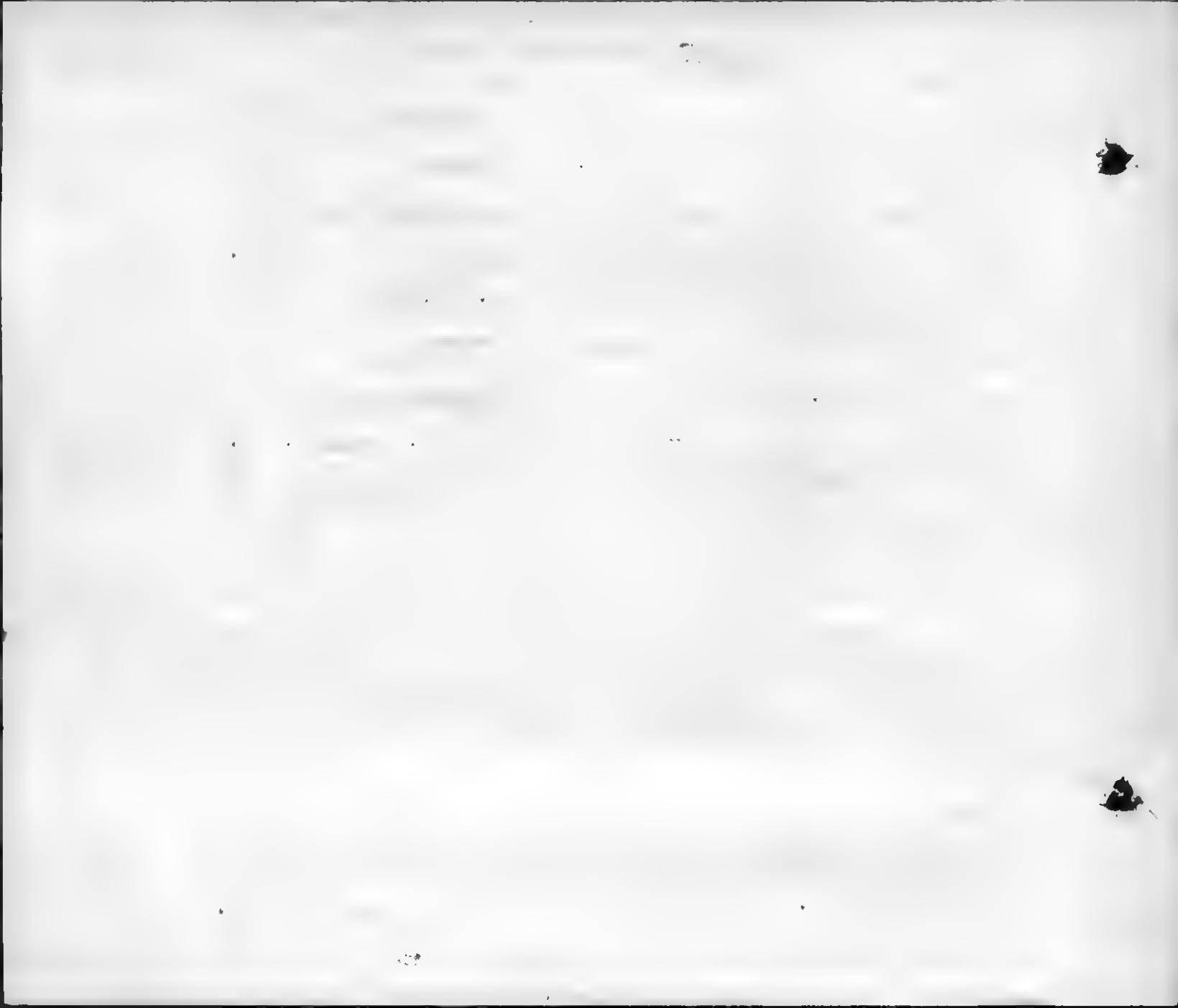
11916 CERTIFICATE OF DEATH

Reg. Dist. No. 11890

1. PLACE OF DEATH a. COUNTY Wicomico		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Delmar		c. LENGTH OF STAY IN lb 50 yrs		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Wicomico	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 408 Chestnut Street		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Delmar		f. STREET ADDRESS 408 Chestnut Street		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) William Cole Nock		First	Middle	Last	4. DATE OF DEATH Oct. 3 1958	Month	Day	Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 28, 1878	9. AGE (In years last birthday) 80 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours	13. IF UNDER 24 HRS. Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Trainman		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME John Wm. Nock		14. MOTHER'S MAIDEN NAME Teresa Stewart		Address					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) No		16. SOCIAL SECURITY NO. 716-03-1592		17. INFORMANT Lena Nock, Delmar, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 33IX DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) Cerebral vascular accident + 3 weeks legionnaires disease and general			INTERVAL BETWEEN ONSET AND DEATH ?
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 20d. INJURY OCCURRED p. m. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from alive on <u>Oct 3, 1958</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <u>L.V. Sohler</u> PHYSICIAN'S NAME (Type) <u>L.V. Sohler</u>		ADDRESS (Street, city or town, state) <u>247 Street, Delmar, Del.</u>					DATE SIGNED <u>Oct 5, 1958</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 5, 1958		22c. NAME OF CEMETERY OR CREMATORIUM First Methodist		22d. LOCATION (City, town or county) Delmar, Del.			
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. S. Gamel Co. Delmar, Del.</u>		ADDRESS		24a. REC'D BY REGISTRAR Oct 7 58		24b. REGISTRAR'S SIGNATURE <u>Int S. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
Page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11885 - CERTIFICATE OF DEATH

Reg. Dist. No.

11891

1. PLACE OF DEATH a. COUNTY Wicomico		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Virginia		b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 27 Months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thornton		d. STREET ADDRESS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springhill Sanitarium				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Mellie West		First	Middle	Last	4. DATE OF DEATH October 10, 1953	Month	Day	Year	
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/12/16		9. AGE (In years less birthday) 72 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY U.S.A.			
13. FATHER'S NAME John S. Nottingham		14. MOTHER'S MAIDEN NAME Molly A. Hobdy							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, or unknown] No.		16. SOCIAL SECURITY NO.		17. INFORMANT		Address Roy Nottingham Eastville, Va.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		Coronary, Heart Disease				INTERVAL BETWEEN ONSET AND DEATH 5 minutes			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Generalized arteriosclerosis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Salisbury		(County) Wicomico	(State) Maryland
21. I certify that I attended the deceased from <u>10/10/53</u> to <u>10-10</u> , 1953, that I last saw the deceased alive on <u>10-10</u> , 1953, and that death occurred at <u>12:30 PM</u> , from the causes and on the date stated above						ADDRESS (Street, city or town, state) Salisbury, Md.		DATE SIGNED 10-10-53	
ACTUAL SIGNATURE <i>Philip A. Insley</i>		M.D.							
PHYSICIAN'S NAME (Type) Philip A. Insley									
22a. BURIAL, CREMATION, REMOVAL (Specify) 10/10/53		22b. DATE THEREOF 10/10/53		22c. NAME OF CEMETERY OR CREMATORIAL Tombstones Cemetery		22d. LOCATION (City, town, or county) Salisbury, Md.		(State) Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND		24a. REC'D BY REGISTRAR OCT 14 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Hines			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

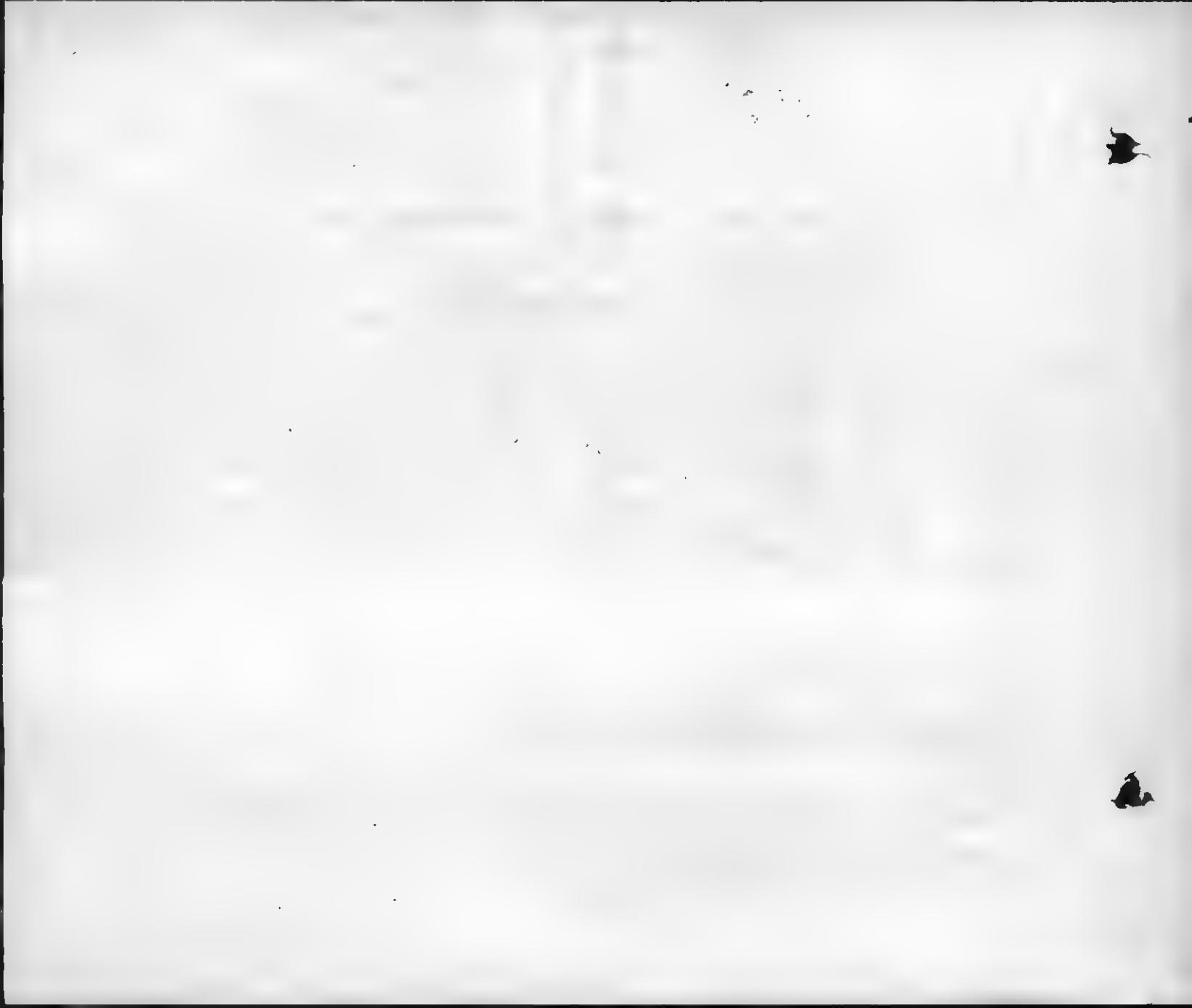
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by a hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										11892				
11886 CERTIFICATE OF DEATH										Reg. Dist. No.				
1. PLACE OF DEATH a. COUNTY Wicomico					MARYLAND					2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury					c. LENGTH OF STAY IN 1b 7 days					b. COUNTY Wicomico				
NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula General Hospital										c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield				
3. NAME OF DECEASED (Type or print) Alexander					First		Middle			d. STREET ADDRESS 137 S. Fourth St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
5. SEX MALE		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH Apr 24-1884		9. AGE (In years from birthday) 79 yrs		10. DATE OF DEATH October 13 1958			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seafood Worker					10b. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) Crisfield, Som. Co. Md.				
13. FATHER'S NAME Robert Page					14. MOTHER'S MAIDEN NAME Leah Ward					12. CITIZEN OF WHAT COUNTRY U.S.A.				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or No unknown) No.					16. SOCIAL SECURITY NO 211-01-1111					17. INFORMANT Father Page-137 S. 4th St. Crisfield, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO 20ix Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)					Cerebral Hemorrhage Cerebral Arteriosclerosis					Address INTERVAL BETWEEN ONSET AND DEATH 7 days				
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at 5 P. M., from the causes and on the date stated above.										ADDRESS (Street, city or town, state)		DATE SIGNED 10/4/58		
ACTUAL SIGNATURE Levi J. Gilson M.D.														
PHYSICIAN'S NAME (Type) Charles H. Kirk Marion Station, Md.														
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 16, 1958.			22c. NAME OF CEMETERY OR CREMATORIUM Upperwell			22d. LOCATION (City, town or county) Crisfield, Som. Co. Md.		(State)				
23. FUNERAL DIRECTOR'S SIGNATURE Charles Kirk Marion Station, Md.					ADDRESS					24a. REC'D BY REGISTRAR DATE OCT 17 '58		24b. REGISTRAR'S SIGNATURE C. H. Kirk		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11917 CERTIFICATE OF DEATH

11893

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) White Haven		c. LENGTH OF STAY IN 1b Lifetime	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) White Haven	
3. NAME OF DECEASED (Type or print) JAMES		First K.	Middle L.
4. DATE OF DEATH Oct. 22		Month	Day
5. SEX Male		6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
8. DATE OF BIRTH 8/20/1886		9. AGE (In years last birthday) 72 yrs.	10. IF UNDER 1 YEAR Months 2 Days 2 Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY Oysterman	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Benjiman Polk		14. MOTHER'S MAIDEN NAME Mary -----	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----	17. INFORMANT Garner Polk, White Haven, Maryland
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4 d. d. l. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO cause (a), stating the under- lying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH Chronic myocarditis	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED White <input checked="" type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>August 17, 1958</u> to <u>Oct 20, 1958</u> , that I last saw the deceased alive on <u>Oct 22, 1958</u> , and that death occurred at <u>3:20 P.M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Hedron, Maryland	
ACTUAL SIGNATURE William Emerich M.D.		DATE SIGNED Oct 23, 1958	
PHYSICIAN'S NAME (Type) William Emerich		Hedron, Maryland 10/22/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/26/58	22c. NAME OF CEMETERY OR CREMATORIUM Polk Private Cem.
22d. LOCATION (City, town, or county) White Haven, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE C. W. Meissner		24a. ADDRESS Bivalve, Maryland	24b. REC'D BY REGISTRAR DATE OCT 28 '58
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11887

CERTIFICATE OF DEATH

11894

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <i>MD</i>		b. COUNTY <i>WORCESTER</i>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>		c. LENGTH OF STAY IN 1b <i>2 weeks</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Berlin</i>		d. STREET ADDRESS <i>11411</i>						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Tunnel Hill General Hospital</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) <i>Edmund Wise</i>		First <i>Edmund</i>	Middle <i>Wise</i>	Last <i>Four</i>	4. DATE OF DEATH <i>October 20 1958</i>	Month <i>October</i>	Day <i>20</i>	Year <i>1958</i>				
5. SEX <i>M</i>		6. COLOR OR RACE <i>WV</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>JUNE 19, 1886</i>		9. AGE (In years last birthday) <i>72 yrs</i>	10. IF UNDER 1 YEAR Months <i>0</i>		11. IF UNDER 24 HRS Months <i>0</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>REALATOR</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>REAL ESTATE</i>		11. BIRTHPLACE (State or foreign country) <i>Berlin MD</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>						
13. FATHER'S NAME <i>Edwin S. Powell</i>		14. MOTHER'S MAIDEN NAME <i>J. ANNIE WISE</i>		Address								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO <i>217-05-0744</i>		17. INFORMANT <i>Mrs. Elizabeth Taylor, Berlin, MD</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>022X</i> DUE TO <i>Arteric Anurysm</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO <i>Teaking Sepsis</i> (c) INTERVAL BETWEEN ONSET AND DEATH <i>unknown</i>						
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						20c. TIME OF INJURY Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from alive on <i>10-21-58</i> , and that death occurred at <i>8:30</i> M, from the causes and on the date stated above								ADDRESS (Street, city or town, state) <i>Salisbury, Md</i>		DATE SIGNED <i>10-21-58</i>		
ACTUAL SIGNATURE <i>William S. Eddy</i>												
PHYSICIAN'S NAME (Type) <i>William S. Eddy</i>												
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>10/23/58</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>EVERGREEN</i>		22d. LOCATION (City, town, or county) <i>BERLIN</i>		(State) <i>MD</i>				
23. FUNERAL DIRECTOR'S SIGNATURE <i>Anna S. Burby</i>		ADDRESS <i>Berlin Md</i>		24a. REC'D BY REGISTRAR <i>OCT 24 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Knapp</i>						

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11888 CERTIFICATE OF DEATH

11895

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Worcester</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore, Md.</i>		c. LENGTH OF STAY IN 1b <i>10 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Gen. Hosp.</i>		e. STREET ADDRESS <i>Baltimore, Md.</i>	
3. NAME OF DECEASED (Type or print) <i>E. A. Purnell</i>		4. DATE OF DEATH <i>Charles</i>	Month <i>Oct</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Col</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7/10/1886</i>
9. AGE (In years lost b. birthday) <i>71 yrs</i>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	
11. BIRTHPLACE (State or foreign country) <i>Baltimore</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>?</i>		14. MOTHER'S MAIDEN NAME <i>1</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>20</i>	
17. INFORMANT <i>W. A. Purnell</i>		Address <i>1007 W. main St.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) DUE TO + Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		Cerebral Hemorrhage Hypertension Cardiovascular Renal Disease INTERVAL BETWEEN ONSET AND DEATH 4 days Indefinite	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>10</i> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) <i>Baltimore</i> (State) <i>Md.</i>	
21. I certify that I attended the deceased from <i>30 Oct 58</i> , 1958, to <i>6 Oct</i> , 1958, that I last saw the deceased alive on <i>6 Oct</i> , 1958, and that death occurred at <i>5th</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>E. A. Purnell</i> M.D. <i>652-W main St. 7 Oct 58</i> PHYSICIAN'S NAME (Type) <i>E. A. Purnell, M.D., Baltimore, Md.</i>		ADDRESS (Street, city or town, state) DATE SIGNED	
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>10-9-58</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Bethel Cem</i>		22d. LOCATION (City, town, or county) <i>Baltimore</i> (State) <i>Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Barker B. Tisch</i>		ADDRESS <i>Baltimore, Md.</i>	
24a. REC'D BY REGISTRAR DATE <i>CCT 14 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Arth S. Thrus.</i>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

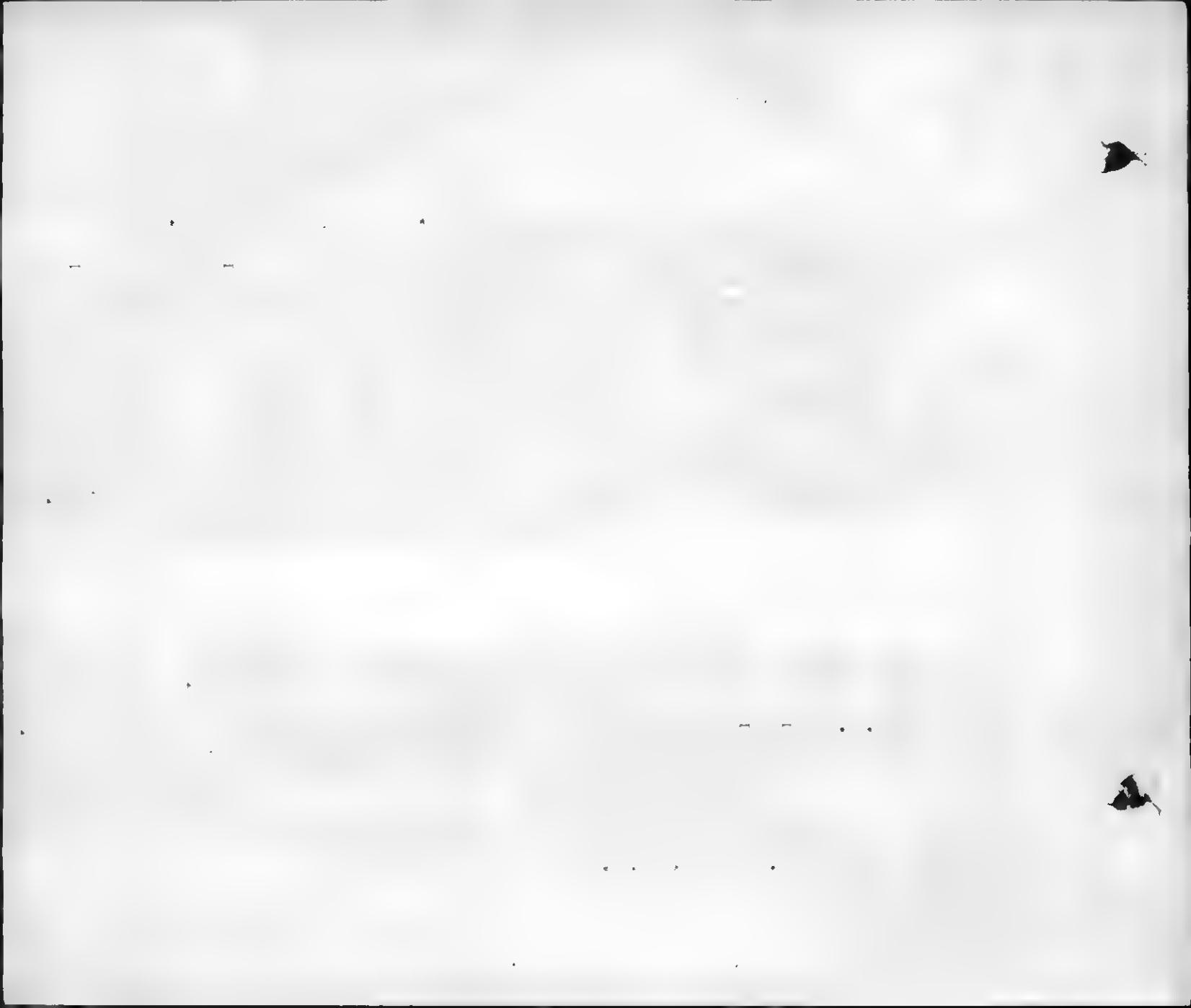
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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11896

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico		11889		2. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		d. STREET ADDRESS 105 W. Philadelphia Ave.		e. S. RULIN' N.E. ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Edward		First Allen	Middle Reynolds	4. DATE OF DEATH 10-28-58	Month Year
5. SEX M		6. COLOR OR RACE W	7. MARRIED WIDOWED <input type="checkbox"/>	8. DATE OF BIRTH MAY 18-1929	9. AGE (In years last birthday) 29 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN		10b. KIND OF BUSINESS OR INDUSTRY GENERAL		11. BIRTHPLACE (State or foreign country) DELAWARE.	
13. FATHER'S NAME PAUL E REYNOLDS		14. MOTHER'S MAIDEN NAME EVELYN M. COOKE		12. CITIZEN OF WHAT COUNTRY? U.S.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Vol. no. or unknown) YES		16. SOCIAL SECURITY NO 217-28-3763		17. INFORMANT Rev Paul E. Reynolds, St. Michael Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crushed chest		DUE TO 816X		Address INTERVAL BETWEEN ONSET AND DEATH Sudden.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) Thrown from car involved in a collision.			
20c. TIME OF INJURY 11:20 a.m. 10-28-58		20d. INJURY OCCURRED Not while at work <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Dover & Johnson	
20f. (City or town) Salisbury		20g. (County) Wicomico		(State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Earl L. Royer, M.D.		MD CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 10-29-58	
22a. BURIAL CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF Oct 30, 1958		22c. NAME OF CEMETERY OR CREMATORIAL Oliver Cemetery	
23. FUNERAL DIRECTOR'S SIGNATURE J. S. Lamberton Harrison, St. Michael's		ADDRESS		24d. REC'D BY REGISTRAR St. Michael's	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kline	
VS. A15ME 5M 2-57		DATE NOV 5 '58			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

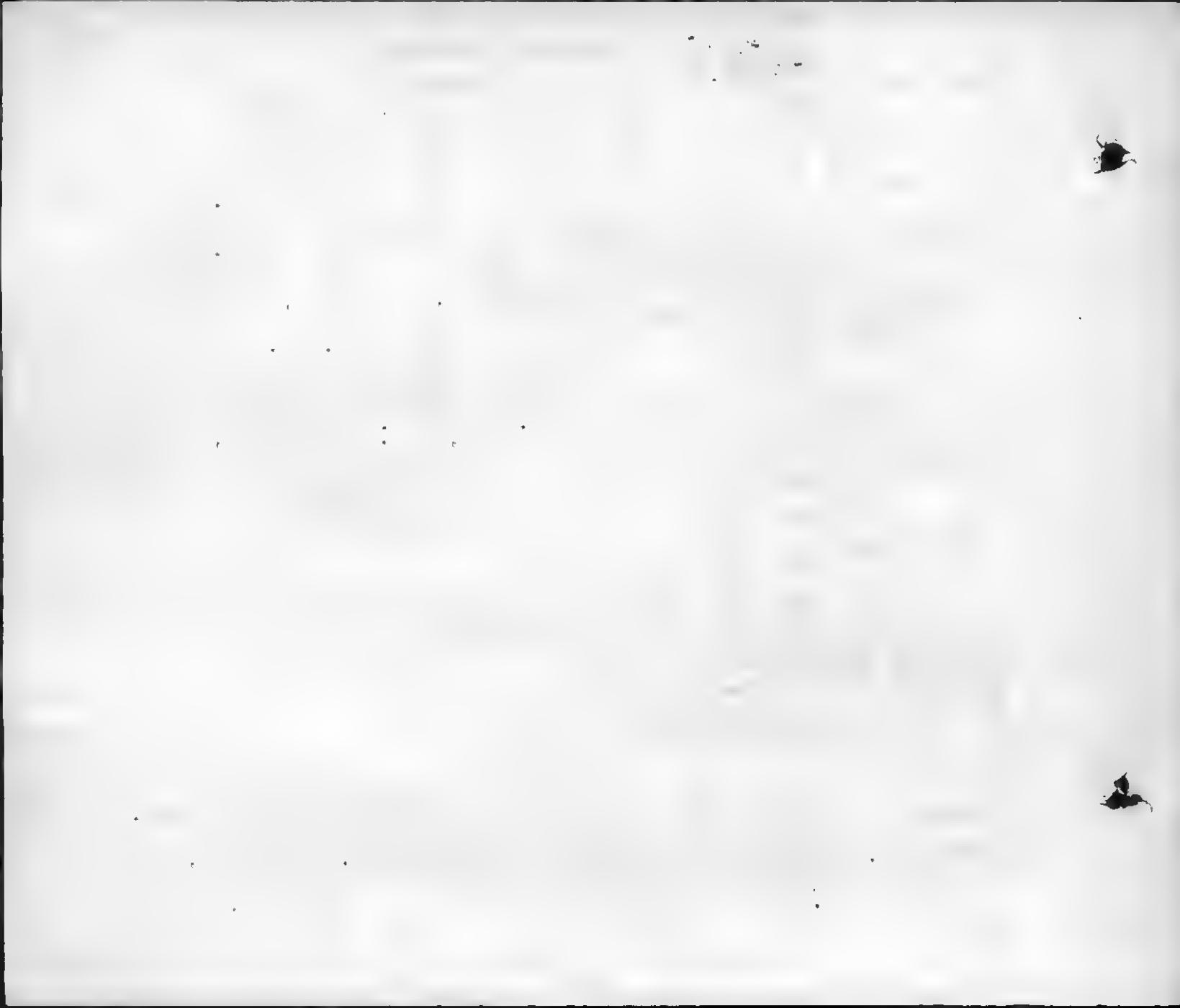
11890

CERTIFICATE OF DEATH

Reg. Dist. No.

11897

1. PLACE OF DEATH a. COUNTY Wicomico		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) b. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b RURAL	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 223 New York Ave		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
3. NAME OF DECEASED (Type or print) BETTIE PARKER RICHARDSON		d. STREET ADDRESS 223 New York Ave.	
4. DATE OF DEATH OCT. 30th 1958		Month	Day
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 21, 1879	
9. AGE (In years lost birthday) 79 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work at Home		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Worcester Co. Md.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME James Redden		14. MOTHER'S MAIDEN NAME Elizabeth Mitchell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Charles A. Skiryen (Daughter) 223 New York, Ave. Salisbury, Maryland		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY- IMMEDIATE CAUSE (a) 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 15 min	
Cerebral Hemorrhage Cerebral Hemorrhage Cerebral Hemorrhage			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cerebral arteriosclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 21</u> , 1958, to <u>Oct 30</u> , 1958, that I last saw the deceased alive on <u>Oct 30</u> , 1958, and that death occurred at <u>3 p.m.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <u>Alberta Mattax M.D.</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>Oct. 31 1958</u>	
PHYSICIAN'S NAME (Type) Dr. Alberta Mattax		711 Camden Ave. Salisbury, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Nov. 2, 1958		22b. DATE THEREOF Parsons Cemetery	
22c. NAME OF CEMETERY OR CREMATORIAL Parsons Cemetery		22d. LOCATION (City, town, or county) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND	
24a. REC'D BY REGISTRAR DATE NOV 3 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11891

CERTIFICATE OF DEATH

11898

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico	MARYLAND	2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE MARYLAND	b. COUNTY TALBOT								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Corona	d. STREET ADDRESS								
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula General Hospital	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
3. NAME OF DECEASED (Type or print) Fannie Montague Roe	First	Middle	Last	4. DATE OF DEATH October 11 1958	Month	Day	Year				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH JULY 24, 1869	9. AGE (In years last birthday) 89 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	Hours	Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework			10b. KIND OF BUSINESS OR INDUSTRY Housewife			11. BIRTHPLACE (State or foreign country) MARYLAND			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME John C. Montague			14. MOTHER'S MAIDEN NAME Emma Williams								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or date of service) No			16. SOCIAL SECURITY NO None			17. INFORMANT Pierson Roe, Corona, Md.			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Intestinal Obstruction									INTERVAL BETWEEN ONSET AND DEATH 72 hrs.		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)			DUE TO								
			DUE TO								
			DUE TO								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)								
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County)		(State)
21. I certify that I attended the deceased from 10-9-1958 to 10-11-1958 , that I last saw the deceased alive on 10-11-1958 , and that death occurred at 9:30 AM , from the causes and on the date stated above.									ADDRESS (Street, city or town, state) 222 N. Division St. - 10-13-58		DATE SIGNED
ACTUAL SIGNATURE Paul G. Cayaves, M.D.											
PHYSICIAN'S NAME (Type) PAUL G. CAYAVES, MD											
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			22b. DATE THEREOF 10/13/58			22c. NAME OF CEMETERY OR CREMATORIAL Spring Hill Cemetery			22d. LOCATION (City, town, or county) Easton (State) Md.		
23. FUNERAL DIRECTOR'S SIGNATURE W. Finneyton Carroll			ADDRESS Easton, Md.			24a. REC'D BY REGISTRAR FACT 16 '58			24b. REGISTRAR'S SIGNATURE Cirilus S. Kraus		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11892

CERTIFICATE OF DEATH

11899

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <i>Pa.</i>		b. COUNTY <i>Lehigh</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Allentown</i>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Peninsula General Hospital</i>		d. STREET ADDRESS <i>640 North 8th St.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>VIOLET</i>		First <i>VIOLET</i>	Middle <i>MAY</i>	Last <i>Ryan</i>	4. DATE OF DEATH <i>October 19 1958</i>	Month <i>October</i>	Day <i>19</i>	Year <i>1958</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 5, 1903</i>	9. AGE (In years last birthday) <i>55 yrs</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Days <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Employee (Saleslady)</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Store</i>		11. BIRTHPLACE (State or foreign country) <i>Allentown, Pa.</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>			
13. FATHER'S NAME <i>Charles Wert</i>		14. MOTHER'S MAIDEN NAME <i>Gertrude Gruber</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <i>No</i>		16. SOCIAL SECURITY NO. <i>Mr. William M. Ryan (Son) 806 East St, Salisbury, Maryland</i>		17. INFORMANT <i>Mr. William M. Ryan (Son) 806 East St, Salisbury, Maryland</i>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: X IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO DUE TO (c)									
<i>Cerebro Vascular accident</i>									
Hypertension (Essential)									
INTERVAL BETWEEN ONSET AND DEATH									
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Salisbury, Md.</i>		(County) <i>Wicomico</i>	(State) <i>Md.</i>
21. I certify that I attended the deceased from <i>10/18/58</i> to <i>10/19/58</i> , that I last saw the deceased alive on <i>10/19/58</i> , and that death occurred at <i>10/19/58</i> M, from the causes and on the date stated above									
ADDRESS (Street, city or town, state) <i>Salisbury, Md.</i>									DATE SIGNED
ACTUAL SIGNATURE <i>Dr. Andrew C. Mitchell</i>		M.D.							
PHYSICIAN'S NAME (Type) <i>Dr. Andrew C. Mitchell</i>		Maryland Ave. Salisbury, Md. Oct. 19/58							
22a. BURIAL, CREMATION OR REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Oct. 21, 1958</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Grandview Cemetery</i>		22d. LOCATION (City, town, or county) <i>Allentown, Pa.</i>		(State) <i>Pa.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>HOLLOWAY & COMPANY</i>		ADDRESS <i>SALISBURY MARYLAND</i>		24a. REC'D BY REGISTRAR <i>OCT 22 '58</i>		24b. REGISTRAR'S SIGNATURE <i>C. Thompson</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please reprove carbon papers. Pages 1 and 2 should be filled with
the registrar prior to burial, cremation, or removal, in any event within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11893

CERTIFICATE OF DEATH

11900

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i>	MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>	b. COUNTY <i>WORCESTER</i>										
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>RURAL</i>	c. LENGTH OF STAY IN 1b <i>SALISBURY</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pocomoke City</i>	d. STREET ADDRESS <i>Second & Cedar St.</i>										
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Peninsula General Hospital</i>	4. DATE OF DEATH <i>October 16-1958</i>	5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <i>MABEL BOSTON</i>	First <i>Schoolfield</i>	Middle <i></i>	Last <i></i>	6. SEX <i>Female</i>	7. COLOR OR RACE <i>White</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. DATE OF BIRTH <i>OCT 1 1880</i>	10. AGE (In years lost birthday) <i>78 yrs</i>	11. IF UNDER 1 YEAR Months <i></i>	12. IF UNDER 24 HRS Days <i></i>	13. DATE Month <i></i>	14. DAY <i></i>	15. YEAR <i>1958</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>	10b. KIND OF BUSINESS OR INDUSTRY <i></i>	11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>	12. CITIZEN OF WHAT COUNTRY <i>USA</i>										
13. FATHER'S NAME <i>JAMES H. BOSTON</i>	14. MOTHER'S MAIDEN NAME <i>SUSAN CLOGG</i>	15. ADDRESS <i>Pocomoke City, MD.</i>											
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>NO</i>	17. SOCIAL SECURITY NO <i>None</i>	18. INFORMANT <i>J. C. STEVENSON</i>	19. INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia, Left Lung</i>	DUE TO <i>1. man</i>	DUE TO <i>2. pneumonia, Left Lung</i>	DUE TO <i>3. Pyelonephritis</i>										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>Arterosclerotic Cardiovascular Disease</i>	(b) <i></i>	(c) <i></i>	6 more +										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) <i></i>	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <i></i>	20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>9/1 1958</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>	20f. (City or town) <i></i>	(County) <i></i>	(State) <i></i>						
21. I certify that I attended the deceased from <i>9/1 1958</i> to <i>10/16 1958</i> that I last saw the deceased alive on <i>10/16 1958</i> and that death occurred at <i>Pocomoke City, MD.</i> from the causes and on the date stated above.	ACTUAL SIGNATURE <i>Rufus S. Gardner Jr.</i>	ADDRESS (Street, city or town, state) <i>PINEBLUFF RD.</i>	DATE SIGNED <i>10/16/58</i>										
22a. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL 10/19/58</i>	22b. DATE THEREOF <i>10/19/58</i>	22c. NAME OF CEMETERY <i>SALEM METHODIST</i>	22d. LOCATION (City, town or county) <i>Pocomoke City, Maryland</i>										
23. FUNERAL DIRECTOR'S SIGNATURE <i>Henry S. Watson</i>	ADDRESS <i>Pocomoke, Md.</i>	24a. REC'D BY REGISTRAR <i>Oct 2 1958</i>	24b. REGISTRAR'S SIGNATURE <i>Elmer S. Krause</i>										



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

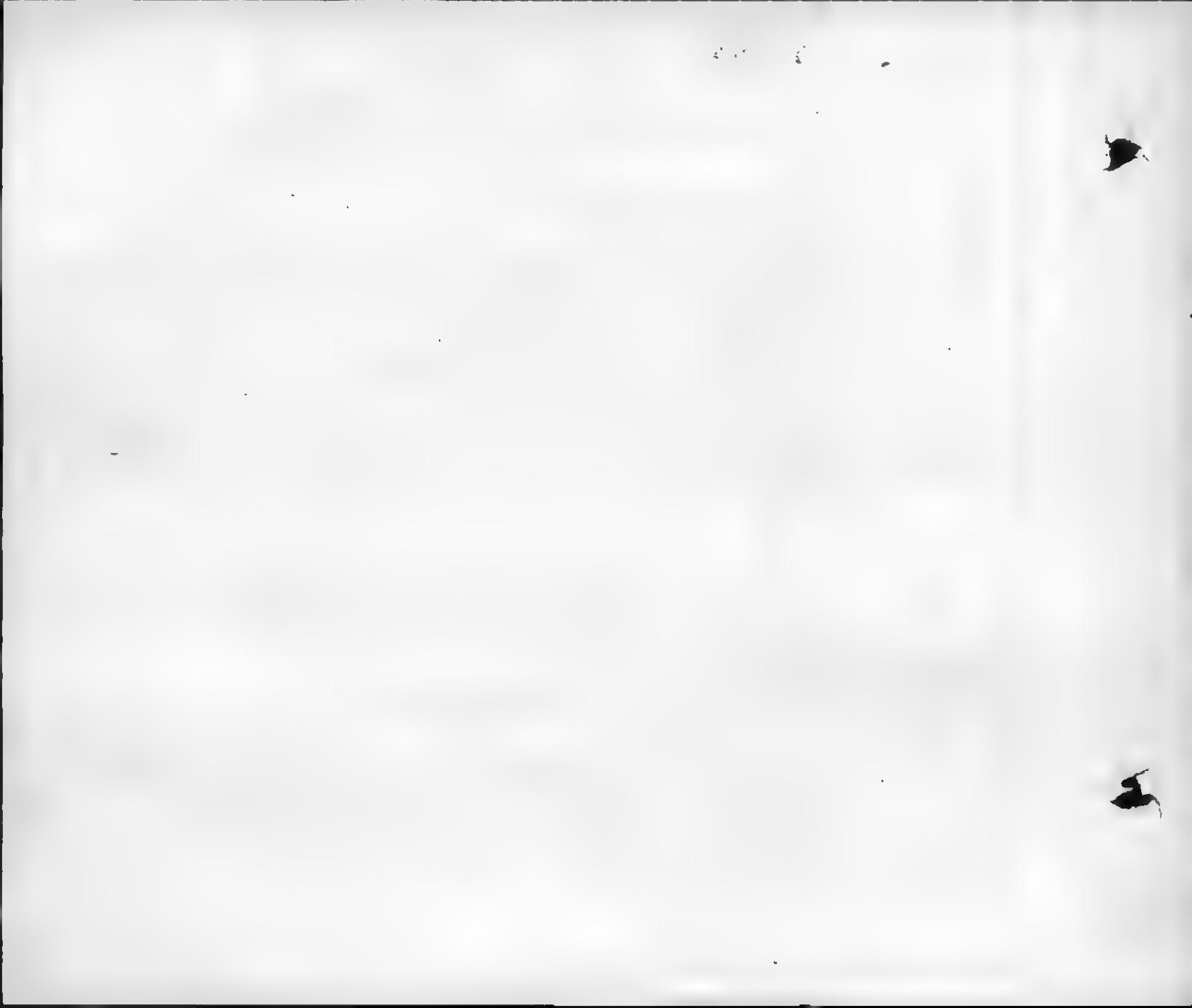
11894

CERTIFICATE OF DEATH

11901

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>DELAWARE</u>		b. COUNTY <u>SUSSEX</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. LENGTH OF STAY IN 1b <u>3 DAYS</u>		CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Seaford</u>		d. STREET ADDRESS <u>RD#1 ATLANTA ROAD</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>Verena Anna SIGRIST</u>		First	Middle	Last	4. DATE OF DEATH <u>October 26, 1958</u>	Month	Day	Year
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN 6, 1886</u>	9. AGE (in years last birthday) <u>72</u>	10. IF UNDER 1 YEAR Months <u>0</u>	11. IF UNDER 24 HRS Days <u>0</u>	12. IF UNDER 24 HRS Hours <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>SWITZERLAND</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>		
13. FATHER'S NAME <u>FRED YONAH</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH YONMATT</u>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>JOSEPH SIGRIST - SEAFORD, DELAWARE</u>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: (IMMEDIATE CAUSE (a)) <u>Myocardial Infarct, acute</u> DUE TO <u>large</u> (b) Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. DUE TO (c)								
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <u>Seaford</u>		(County) <u>Sussex</u>	(State) <u>MARYLAND</u>	
21. I certify that I attended the deceased from <u>10-23</u> , 19 <u>58</u> , to <u>10-26</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>10-26</u> , 19 <u>58</u> , and that death occurred at <u>7A</u> M, from the causes and on the date stated above ADDRESS (Street, city or town, state) <u>Seaford, Del</u> DATE SIGNED <u>10-26-58</u>								
ACTUAL SIGNATURE <u>Wilma R. Elliott</u>		PHYSICIAN'S NAME (Type) <u>M.D.</u>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL OCT 29, 1958</u>		22b. DATE THEREOF <u>10-29-58</u>		22c. NAME OF CEMETERY OR CREMATORIUM <u>WICOMICO MEM. PARK</u>		22d. LOCATION (City, town, or county) <u>SALISBURY, MARYLAND</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Medford L. Watson</u>		ADDRESS <u>Seaford, Del.</u>		24a. REC'D BY REGISTRAR Date <u>Oct 29 1958</u>		24b. REGISTRAR'S SIGNATURE <u>Amelia S. Friend</u>		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11895

CERTIFICATE OF DEATH

11902

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Talbot		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 3 yrs. 22 da.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sherwood		d. STREET ADDRESS --		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First Archie	Middle B.	Last Sinclair	4. DATE OF DEATH October 28, 1958	Month October	Day 28	Year 1958
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 22, 1883	9. AGE (In years last birthday) 75 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Thomas James Sinclair		14. MOTHER'S MAIDEN NAME Mary Louise Bromwell						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Unk. --		16. SOCIAL SECURITY NO 217-03-15824		17. INFORMANT Deer's Head State Hospital, Salisbury, Md.		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) General metastases						INTERVAL BETWEEN ONSET AND DEATH		
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Adenocarcinoma of sigmoid						4 yrs ?		
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerotic heart disease with aortic stenosis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Deer's Head State Hospital		(County) Salisbury
								(State) Md.
21. I certify that I attended the deceased from October 5, 1955, to October 28, 1958, that I last saw the deceased alive on October 28, 1958, and that death occurred at 6:27 P.M. from the causes and on the date stated above.								
ACTUAL SIGNATURE G. Kosmahl		M.D.		ADDRESS (Street, city or town, state) Deer's Head State Hospital		DATE SIGNED 10/29/58		
PHYSICIAN'S NAME (Type) G. Kosmahl, M. D.				Salisbury, Maryland				
22a. BURIAL, CREMATION: REMOVAL (Specify) Burial		22b. DATE THEREOF Oct 31, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Sherwood Cemetery		22d. LOCATION (City, town, or county) Sherwood		(State) Md.
23. FUNERAL DIRECTOR'S SIGNATURE J. Hamilton Harrison, St. Michaels		ADDRESS Md.		24a. REC'D BY REGISTRAR DATE NOV 3 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11896 CERTIFICATE OF DEATH

Reg. Dist. No. 11903

1. PLACE OF DEATH a. COUNTY Wicomico		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION John B. Parsons Home		e. STREET ADDRESS Legmon Hill	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First MARY	Middle LOU	Last SELEMONS
4. DATE OF DEATH	Month OCTOBER	Day 15th, 58	Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> Single	8. DATE OF BIRTH Aug. 20, 1875
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Quantico, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Albert B. Slemons		14. MOTHER'S MAIDEN NAME Elizabeth Ker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Records: John B. Parsons Home Address: Salisbury, Maryland	
17. INFORMANT John B. Parsons Home		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerotic Heart Disease DUE TO spasms Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)	
		INTERVAL BETWEEN ONSET AND DEATH Sudden	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) Delmar		(County) Delaware	
(State) Delaware			
21. I certify that I attended the deceased from 7/1 , 19 58 , to 10/17 , 19 58 , that I last saw the deceased alive on 10/14 , 19 58 , and that death occurred at M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 402 S. Division St. Salisbury, Md.	
ACTUAL SIGNATURE Fred R. Gramse		DATE SIGNED Oct. 17 /1958	
PHYSICIAN'S NAME (Type) Dr. Fred R. Gramse			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 18. /58	
22c. NAME OF CEMETERY OR CREMATORIAL M.E. Methodist Cem.		22d. LOCATION (City, town, or county) Delmar, Delaware	
(State)			
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND	
24a. REC'D BY REGISTRAR DATE OCT 2 1958		24b. REGISTRAR'S SIGNATURE J. S. Gramse	

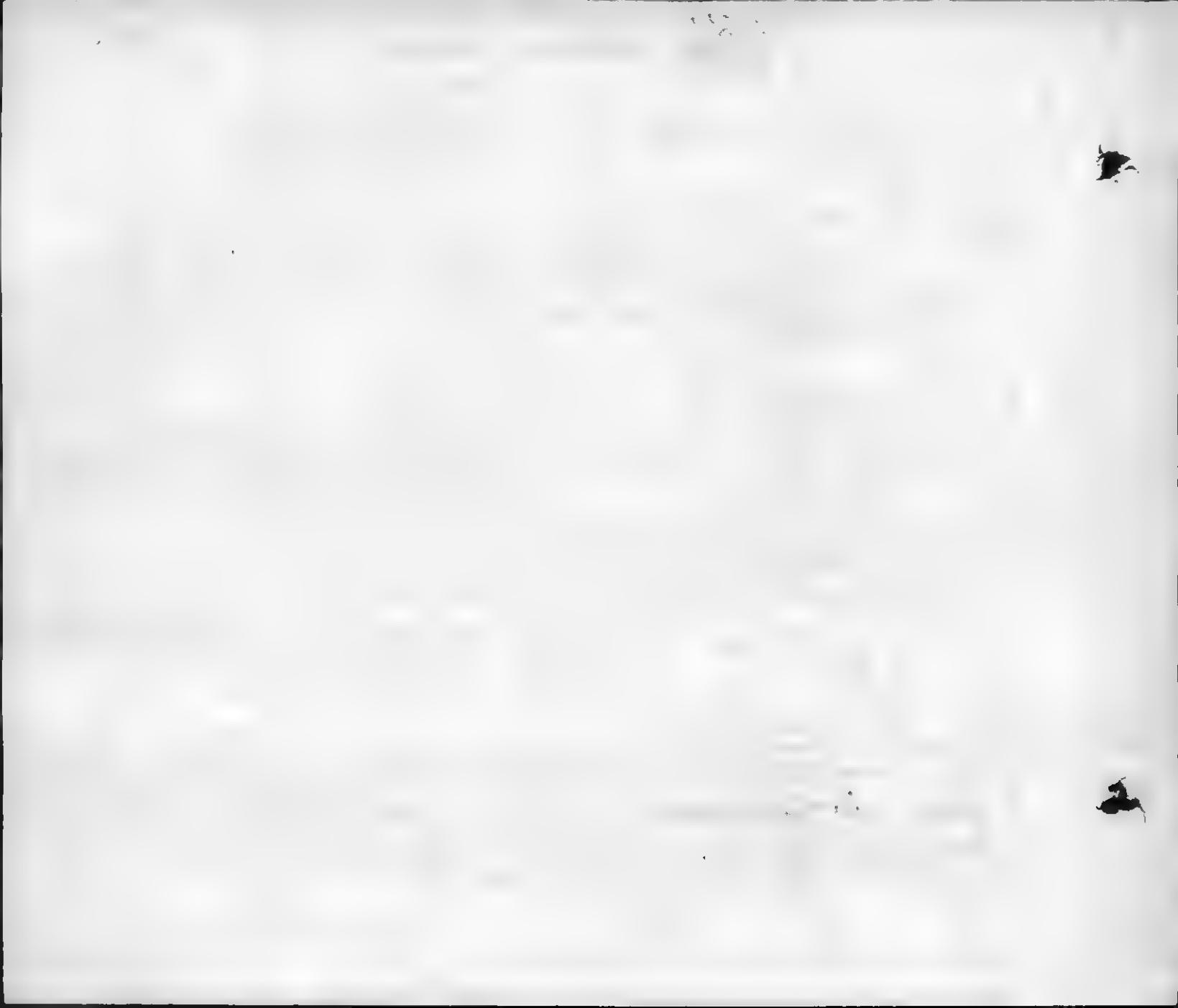


MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11897 CERTIFICATE OF DEATH

11901
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury, Maryland		c. LENGTH OF STAY IN 1b 3yrs-16days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waldorf, Maryland			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		d. STREET ADDRESS unk		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Susan	Middle Etta	Last Smith	4. DATE OF DEATH Oct. 5, 1958	Month Oct.	Day 5	Year 1958
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH June 28, 1868	9. AGE (In years last birthday) 90 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unk		10b. KIND OF BUSINESS OR INDUSTRY unk		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Nathaniel Anderson			14. MOTHER'S MAIDEN NAME Eugenia Lipford			Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unk		16. SOCIAL SECURITY NO unk		17. INFORMANT Hospital Records, Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular disease w/coronary insufficiency 420.1 DUE TO Arteriosclerosis general Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause, if any: (b) DUE TO Arteriosclerosis general (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 21, 1955, to Oct. 5, 1958, that I last saw the deceased alive on Oct. 5, 1958, and that death occurred at 5:00 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Salisbury, Maryland DATE SIGNED 10/5/58							
ACTUAL SIGNATURE Dr. Juerman.		M.D.					
PHYSICIAN'S NAME (Type) V. Juerman, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-8-58		22c. NAME OF CEMETERY OR CREMATORIUM Riverside Cemetery		22d. LOCATION (City, town, or county) Richmond (State) Va.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Juerman Bros.		ADDRESS 1661-6601 Hope St. SE.		24a. REC'D BY REGISTRAR OCT 7 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11905

11898 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH

a. COUNTY

Wicomico

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

SALISBURY

c. LENGTH OF STAY IN 1b
RURAL and give nearest town)

2 (days)

d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION

Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)

a. STATE

MARYLAND

b. COUNTY

Somerset

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Princess Ave.

d. STREET ADDRESS

e. IS RESIDENCE
ON A FARM?YES NO 3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

October 7, 1958

Monthly Day Year

5. SEX

6. COLOR OR RACE

Male White

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

Sept 16 1892

9. AGE (In years
last birthday)

66 yrs.

10. IF UNDER 1 YEAR

Months Days

Hours

Min

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY

13. FATHER'S NAME

John Salum

14. MOTHER'S MAIDEN NAME

Helena Nelson

Address

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)

16. SOCIAL SECURITY NO

17. INFORMANT

Mr Ernest Tracy Sackley, MD

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

420.1

DUE TO

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause first.

(b)

DUE TO

(c)

Myocardial Infarct, acute

INTERVAL BETWEEN
ONSET AND DEATH

3 days

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(If either, notify medical examiner)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19 p. m.20d. INJURY OCCURRED
While at work Not while at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from 10-5, 1958, to 10-7, 1958, that I last saw the deceased
alive on 10-7, 1958, and that death occurred at 10:10 A.M. from the causes and on the date stated above

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATURE

William B. Elish, M.D. Baltimore, Md. 10-7-58

PHYSICIAN'S
NAME (Type)22a. BURIAL, CREMATION OR
REMOVAL (Specify)

Burial 10-9-58

22b. DATE THEREOF

10-9-58

22c. NAME OF CEMETERY OR CREMATORIUM

Baltimore Cemetery, Inc., 1001 Fernside Ave., Baltimore, Md.

22d. LOCATION (City, town, or county)

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

Lester B. Watson, Funeral Director

ADDRESS

Princess Anne Rd.

24a. REC'D BY REGISTRAR

Oct 15 '58

24b. REGISTRAR'S SIGNATURE

Arthur S. Kraus



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 11 File No. 34 10-1-58 et

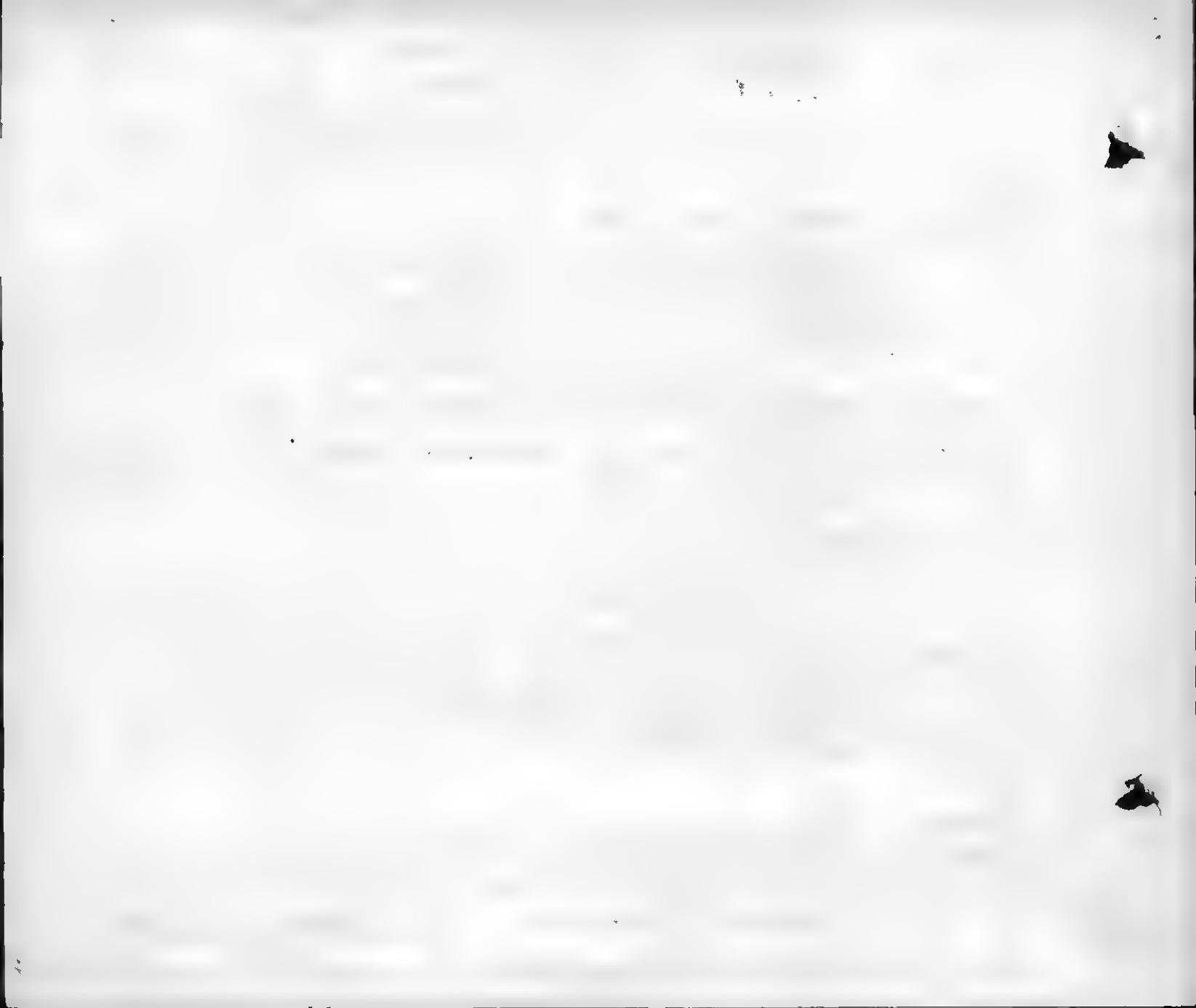
11906

11899

CERTIFICATE OF DEATH

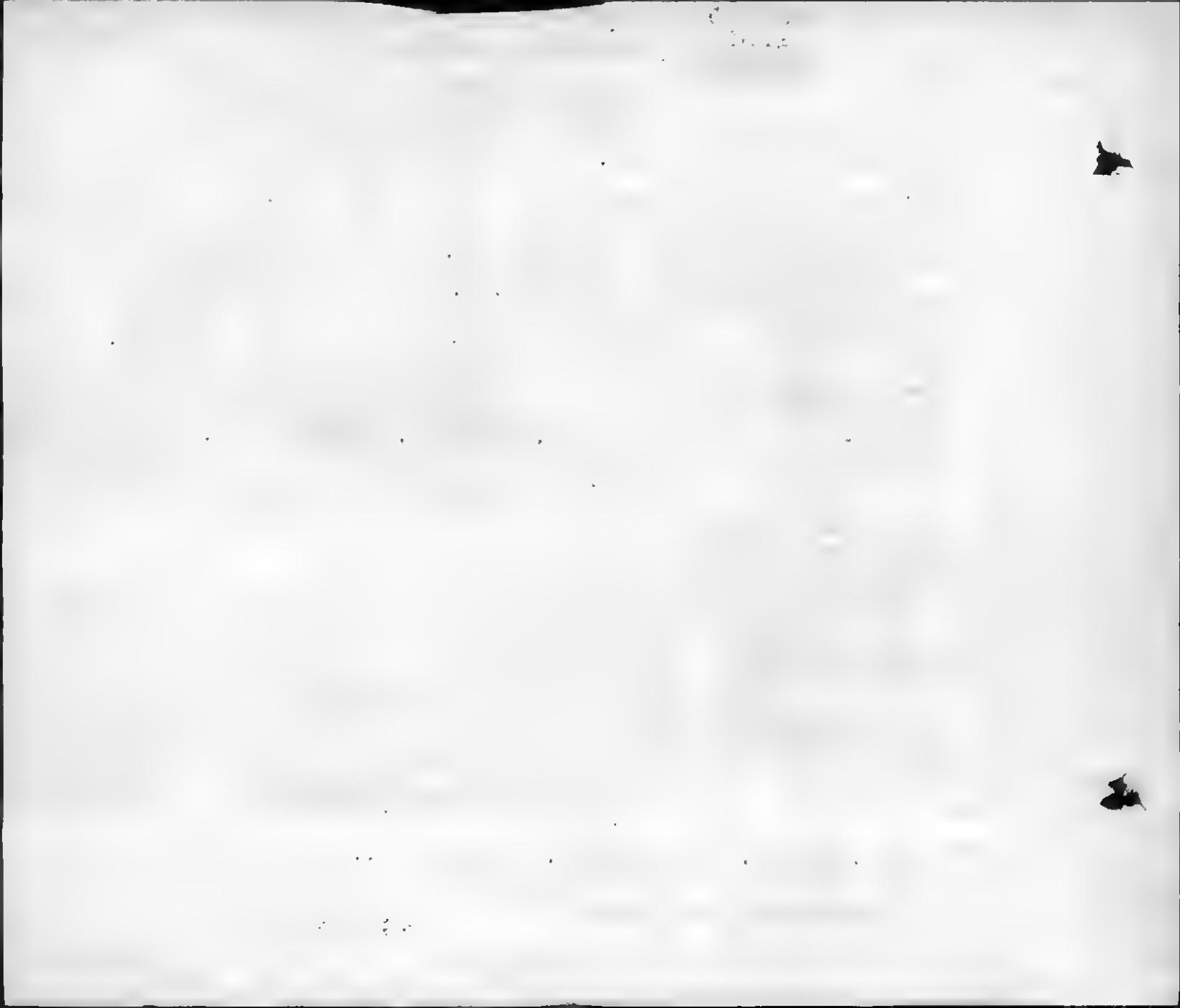
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>SALISBURY</i>		c. LENGTH OF STAY IN 1b <i>6 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Peninsula General Hospital</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>SALISBURY</i>	
3. NAME OF DECEASED (Type or print) <i>MARY ELIZABETH</i>		First <i>MARY</i>	Middle <i>ELIZABETH</i>
4. DATE OF DEATH <i>October 6, 1958</i>		Last <i>THOMAS</i>	Month Day Year
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Colored</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5/17/1919</i>
10a. USUAL OCCUPAT. ON (Give kind of work done during most of working life, even if retired) <i>Saler</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>See Andrew Rutter</i>		14. MOTHER'S MAIDEN NAME <i>Brookside Jones</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Thomasville 5-17 5 Jordan St</i>	
17. INFORMANT <i>Thomasville 5-17 5 Jordan St</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>174X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ADDRESS (Street, city or town, state)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>10/3, 1958</i> to <i>10/6, 1958</i> , that I last saw the deceased alive on <i>10/6, 1958</i> , and that death occurred at <i>1 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>DR. WILLIAM B. SMITH</i>		ADDRESS (Street, city or town, state) DR. WILLIAM B. SMITH The Medical Center Rt. 2, Salisbury, Md. DATE SIGNED <i>10/6/58</i>	
PHYSICIAN'S NAME (Type) <i>DR. WILLIAM B. SMITH</i>		22a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>	
22b. DATE THEREOF <i>10/10/1958</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Green acres</i>	
22d. LOCATION, (City, town, or county) <i>Salisbury</i>		(State) <i>Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Clinton Stewart</i>		24a. REC'D. BY REGISTRAR Oct 14 1958 DATE	
ADDRESS <i>Salisbury Md.</i>		24b. REGISTRAR'S SIGNATURE <i>John S. Evans</i>	



HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										11907					
11900 CERTIFICATE OF DEATH										Reg. Dist. No.					
1. PLACE OF DEATH a. COUNTY Wicomico					2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland					b. COUNT Wicomico					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury					c. LENGTH OF STAY IN 1b 2 Hrs.					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula General Hospital					d. STREET ADDRESS Merritt Mill Rd.,					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First GEORGE	Middle WILSON	Last TILGHMAN, Sr		4. DATE OF DEATH 10		Month 10	Day 1	Year 1958					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct, 10, 1876		9. AGE (In years at birthday) 81		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Real Estate			10b. KIND OF BUSINESS OR INDUSTRY Broker			11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.						
13. FATHER'S NAME George Tilghman					14. MOTHER'S MAIDEN NAME Martha Emmily Adkins					Address					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO 244-10-347			17. INFORMANT Mr. George W. Tilghman, Sr. Salisbury, Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) Part I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 4 d.o. 1 DUE TO Coronary Occlusion INTERVAL BETWEEN ONSET AND DEATH 2 hrs															
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)															
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)												20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) Salisbury (State) Maryland						
21. I certify that I attended the deceased from 10/1 , 19 58 , to 10/1 , 19 58 , that I last saw the deceased alive on 10/6/58 , 19 58 , and that death occurred at 4:45 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE Fred R. Gramse, M.D. 10/2/58 DATE SIGNED PHYSICIAN'S NAME (Type) Dr. Fred R. Gramse 402 S. Division St., Salisbury, Maryland															
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 10/1/58			22b. DATE THEREOF			22c. NAME OF CEMETERY OR CREMATORIUM Parsons Cemetery			22d. LOCATION (City, town, or county) Salisbury, Maryland (State) Maryland						
23. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson Salisbury, Maryland						24a. REC'D BY REGISTRAR Oct 1, '58									
ADDRESS 142 W. Main St.						24b. REGISTRAR'S SIGNATURE John S. Kraus									



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

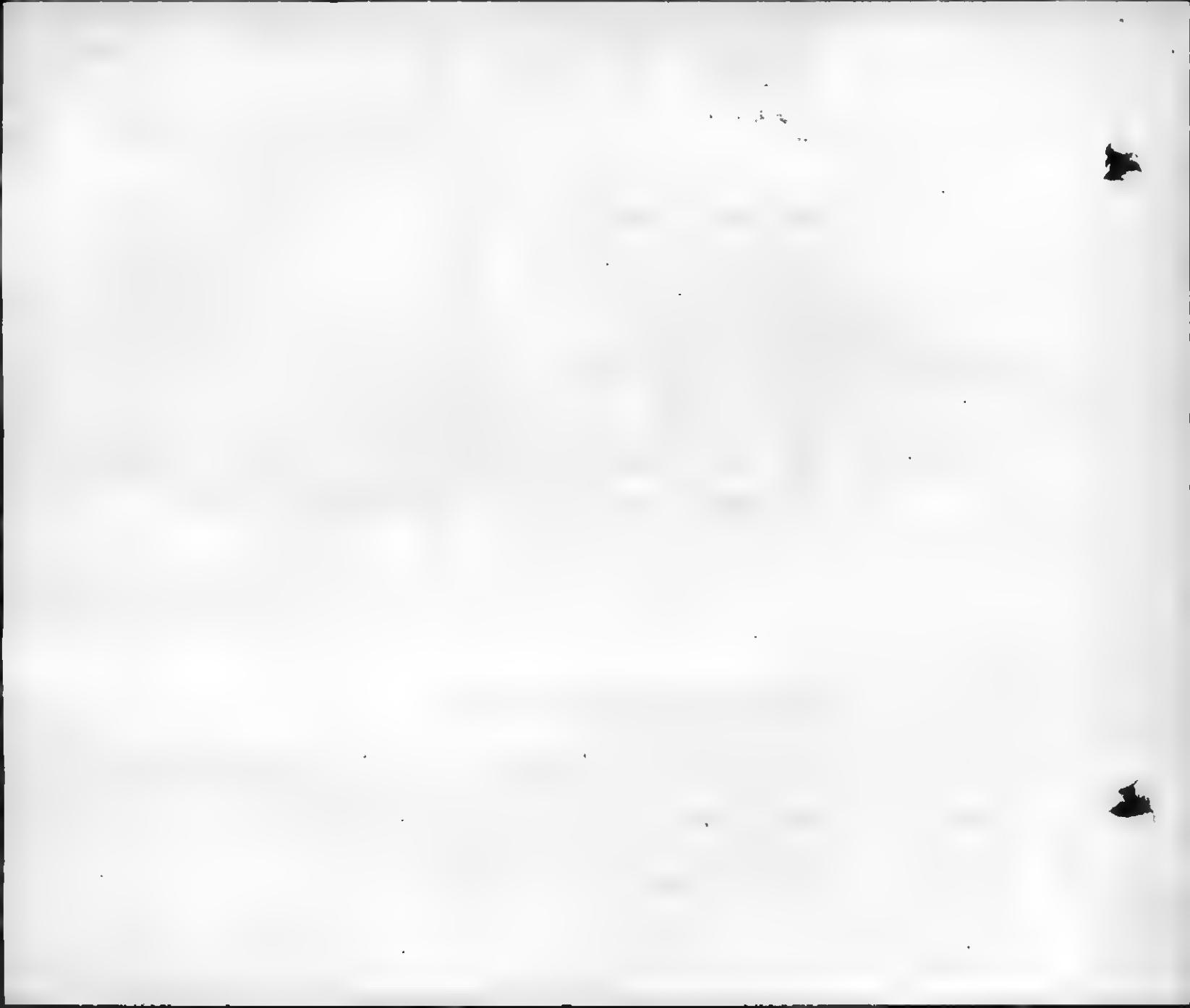
11901

CERTIFICATE OF DEATH

11908

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 28 days		b. COUNTY Worcester		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Stockton		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				d. STREET ADDRESS				
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First William	Middle E.	Last Tull	4. DATE OF DEATH Oct. 14	Month Oct.	Year 1958	
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/17/1871	9. AGE (In years last birthday) 87 yrs	IF UNDER 1 YEAR Months Days Hours Min		
10. USUAL OCCUPATION (Give kind of work done during may of working life, even if retired) Retired Postmaster				10b. KIND OF BUSINESS OR INDUSTRY U.S. Post Office		11. BIRTHPLACE (State or foreign country) Maryland, Stockton		
13. FATHER'S NAME Miles Tull				12. CITIZEN OF WHAT COUNTRY? USA				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) None				16. SOCIAL SECURITY NO		17. INFORMANT Hospital Records Address Mrs. Miles W. Tull, Stockton, MD		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 177X DUE TO Generalized metastases with spontaneous fracture of left femur Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Carcinoma of prostate (c)				INTERVAL BETWEEN ONSET AND DEATH ?				
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive cardiovascular disease				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from Sept. 16, 1958, to Oct. 14, 1958, that I last saw the deceased alive on Oct. 14, 1958, and that death occurred at 1 P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. Deer's Head State Hospital DATE SIGNED ACTUAL SIGNATURE <i>G. Kosmahl</i> 10/14/58								
PHYSICIAN'S NAME (Type) G. Kosmahl, M. D.		Salisbury, Maryland						
22a. BURIAL, CREMATION, 22b. DATE THEREOF REMOVAL (Specify) Burial Oct. 17/58		22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS		22d. LOCATION (City, town, or county) Stockton, MD			(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Wayne & Sonner		ADDRESS Snow Hill, MD		24a. REC'D BY REGISTRAR OCT 17 1958		24b. REGISTRAR'S SIGNATURE Arthur S. Trahan		



1 X
FOR STATE
HEALTH DEPT.
11909
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11909

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico	MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Wicomico
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	c. LENGTH OF STAY IN 1b 50 Yrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 331 Camden Ave.	d. STREET ADDRESS 331 Camden Ave.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) Nina	First	Middle	Lost	4. DATE OF DEATH 10-	Month	Day	Year
	Venables	Veale		10-	3	19	58

5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH June 17, 1888	9. AGE (In years last birthday) 70 yrs	10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housemother	10b. KIND OF BUSINESS OR INDUSTRY College	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13. FATHER'S NAME George C. Venables	14. MOTHER'S MAIDEN NAME Margaret Langsdale	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 217-10-2286A	17. INFORMANT Mrs Sara Walker, Baltimore, Md.
		Address Baltimore, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	Address Baltimore, Md.
PART I. DEATH WAS CAUSED BY; IMMEDIATE CAUSE (a) Coronary Occlusion	INTERVAL BETWEEN ONSET AND DEATH 1 week
4 DUE TO Conditions, if any, which gave rise to immediate cause (b) DUE TO (c)	

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Earl L. Royer	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED 10-6-58	
EXAMINER'S NAME (Type) Earl L. Royer, M.D.	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
22a. BURIAL/CREMATION REMOVAL (Specify) Burial	22b. DATE THEREOF 10/6/58	22c. NAME OF CEMETERY OR CREMATORIAL Quantico Methodist	22d. LOCATION (City, town, or county) Quantico, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson Salisbury, Maryland	24a. REG. DEPT. REGISTRAR OCT 8 58	24b. REG. STAR'S SIGNATURE Arthur S. French
ADDRESS 700 Main & Barker		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11910

11918 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY o <i>Harford</i>		c. LENGTH OF STAY IN 1b o <i>1 day</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE o <i>Maryland</i>		b. COUNTY o <i>Harford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) o <i>Harford</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) o <i>Georgetown</i>		d. STREET ADDRESS o <i>Georgetown</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION o <i>None</i>				4. DATE OF DEATH o Month <i>Oct</i> Day <i>9</i> Year <i>1958</i>			
3. NAME OF DECEASED (Type or print) o <i>John M. Moore</i>		First <i>John</i> Middle <i>M.</i> Last <i>Moore</i>		5. SEX o <i>M</i>		6. COLOR OR RACE o <i>C</i>	
7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH o <i>May 19 1891</i>		9. AGE (in years last birthday) yrs o <i>68</i>		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY during most of working life, even if retired) o <i>None</i>		11. BIRTHPLACE (State or foreign country) o <i>Georgetown</i>		12. CITIZEN OF WHAT COUNTRY? o <i>U.S.A.</i>			
13. FATHER'S NAME o <i>John M. Moore</i>		14. MOTHER'S MAIDEN NAME o <i>None</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) o <i>No</i>		16. SOCIAL SECURITY NO. o <i>None</i>		17. INFORMANT o <i>Elaine Nichols</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: - IMMEDIATE CAUSE (a) + DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) o <i>Degenerative heart disease, a. from 5 cerebral arteriosclerosis, cerebral</i>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) o <i>6526 Main St., Salisbury, Md.</i>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>July 1958</i> to <i>Oct. 1958</i> that I last saw the deceased alive on <i>July 1958</i> and that death occurred at <i>6526 Main St., Salisbury, Md.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE <i>E.A. Farnell, M.D.</i> DATE SIGNED <i>Oct. 1958</i>							
22a. BURIAL, CREMATION, REMOVAL, (Specify) o <i>Burial Oct. 20 1958</i>		22b. DATE THEREOF o <i>Oct. 20 1958</i>		22c. NAME OF CEMETERY OR CREMATORIAL o <i>Georgetown Cemetery</i>		22d. LOCATION (City, town, or county) (State) o <i>Georgetown, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE o <i>Brooks M. West</i>		ADDRESS		24a. REC'D. BY REGISTRAR DATE <i>Oct. 21 1958</i>		24b. REGISTRAR'S SIGNATURE o <i>John S. Hart</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11903 CERTIFICATE OF DEATH

11911

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico			2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			b. COUNTY Dorchester		
c. LENGTH OF STAY IN 1b 9 days			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hurlock		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital			d. STREET ADDRESS Front Street		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First George	Middle Medford	Last Wheatley	4. DATE OF DEATH October 30, 1958	Month Day Year
5. SEX Male	6. COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 8, 1866	9 AGE (In years last birthday) 92 yrs	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer (Retired)			10b. KIND OF BUSINESS OR INDUSTRY Farm	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Margaret Ellen Wheatley		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) Unknown No			16. SOCIAL SECURITY NO Unknown	17. INFORMANT Deer's Head State Hospital, Salisbury, Maryland	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1			INTERVAL BETWEEN ONSET AND DEATH Years		
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b)			Arteriosclerotic cardiovascular disease		
DUE TO (c)			Arteriosclerosis, generalized		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cerebral thrombosis					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)
21. I certify that I attended alive on October 30, 1958		he deceased from Oct. 21, 1958 to Oct. 30, 1958, that I last saw the deceased and that death occurred at 4:00 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>V. Maldve</i>		ADDRESS (Street, city or town, state) Deer's Head State Hospital DATE SIGNED 10/30/58			
PHYSICIAN'S NAME (Type) L. V. Maldve, M.D.		Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 2, 1958	22c. NAME OF CEMETERY OR CREMATORIUM East New Market Cemetery	22d. LOCATION (City, town, or county) East New Market, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE J. J. Frampton and Son, Federalsburg, Maryland		ADDRESS J. J. Frampton and Son, Federalsburg, Maryland		24a. REC'D BY REGISTRAR DATE 10/30/58	24b. REGISTRAR'S SIGNATURE <i>J. J. Frampton</i>

1000

1000

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

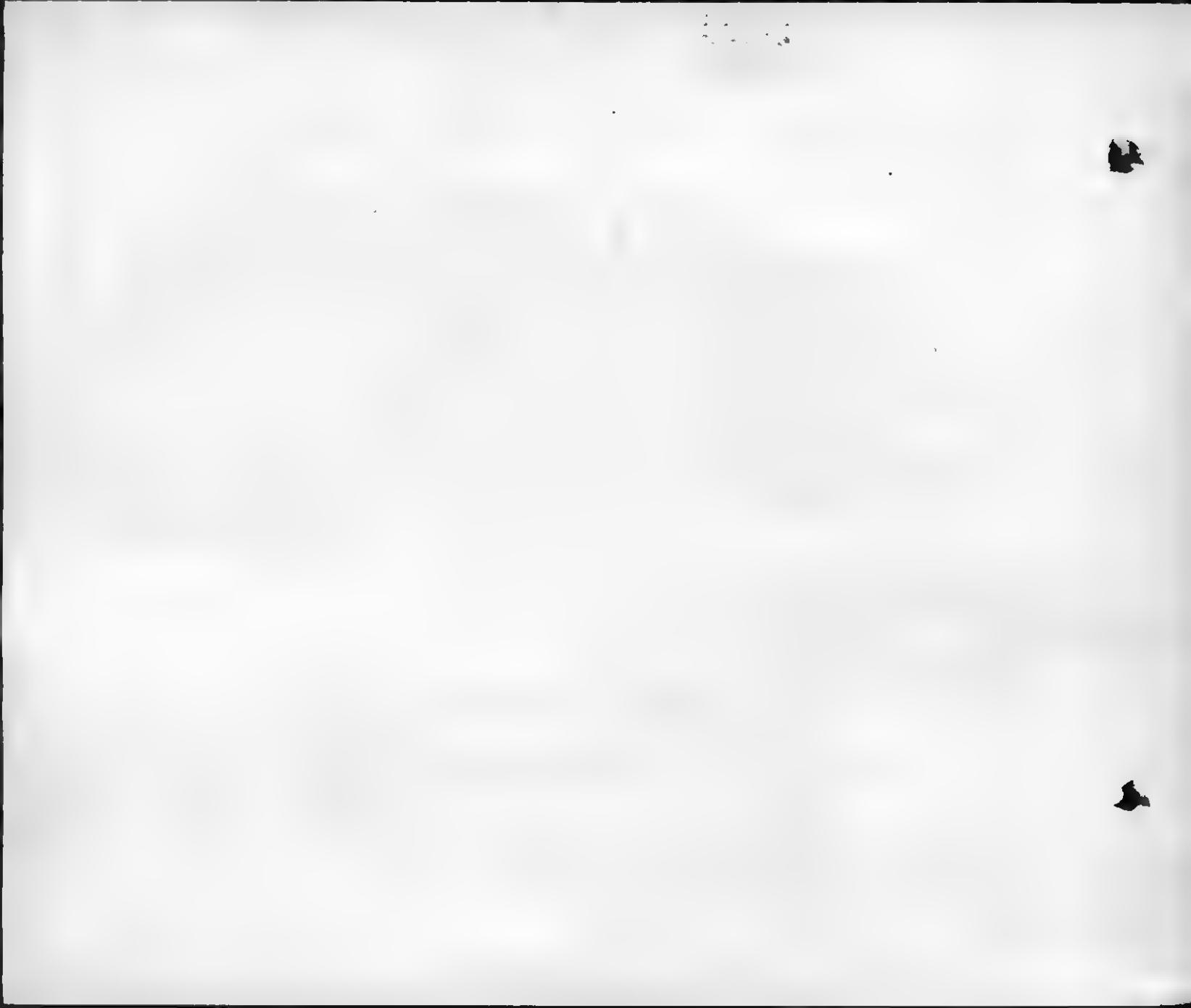
11904

CERTIFICATE OF DEATH

11912

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Delaware</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>DELAWARE</u>		b. COUNTY <u>SUSSEX</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN lb <u>4 DAYS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SEAFORD</u>		d. STREET ADDRESS <u>RD #2 MTLION AREA</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>RD #2 MTLION AREA</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Raymond SPICER</u>		First	Middle	Lost	4. DATE OF DEATH <u>Wheatley</u>	Month	Day	Year	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 3 1891</u>	9. AGE (In years last birthday) <u>67</u> yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARM OWNER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>		11. BIRTHPLACE (State or foreign country) <u>DELAWARE</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>FRANCIS W. WHEATLEY</u>		14. MOTHER'S MAIDEN NAME <u>ANNA SPICER</u>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>—</u>		17. INFORMANT <u>MRS ROLAND C. WRIGHT - SEAFORD, DEL.</u>		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Myocardial Infarct, acute</u> INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>Salisbury</u>		(County) <u>MD</u>	(State) <u>MD</u>
21. I certify that I attended the deceased from <u>11-23-1958</u> to <u>10-27-1958</u> , that I last saw the deceased alive on <u>10-26-1958</u> , and that death occurred at <u>7:05 PM</u> , from the causes and on the date stated above									
ACTUAL SIGNATURE <u>William S. Elieff</u>		ADDRESS (Street, city or town, state) <u>Salisbury, MD</u>							DATE SIGNED <u>10-27-58</u>
PHYSICIAN'S NAME (Type) <u>William S. Elieff M.D.</u>									
22a. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>OCT 30, 1958</u>		22c. NAME OF CEMETERY OR CREMATORIAL <u>1000 FELLOWS Cem.</u>		22d. LOCATION (City, town, or county) <u>SEAFORD DE CAWARE</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Medford L. Watson - SEAFORD, DEL.</u>		ADDRESS		24a. REC'D BY REGISTRAR <u>OCT 30 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

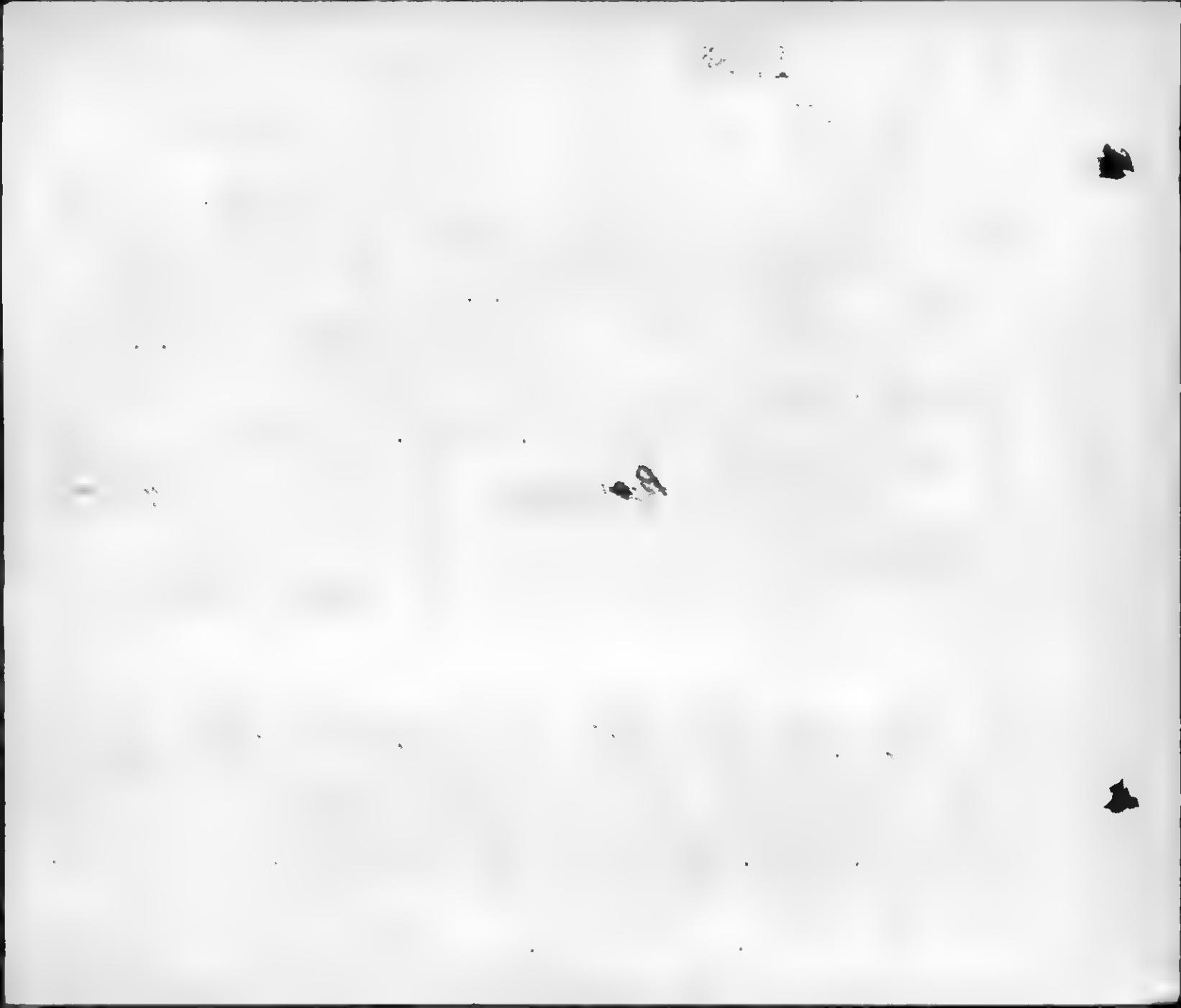
11905 CERTIFICATE OF DEATH

Reg. Dist. No.

11913

1. PLACE OF DEATH a. COUNTY Wicomico		MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN lb 10 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		d. STREET ADDRESS 110 West London Ave.,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula General Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARYNEAL		First MARIAN	Middle WOOD	4. DATE OF DEATH Feb. 9, 1958	Month 10	Day 13	Year 1958
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Feb. 9, 1917	9. AGE (In years last birthday) 41 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Never Work		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harry E. Wood		14. MOTHER'S MAIDEN NAME Cornelia Plitt					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Harry E. Wood, Same		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		Pyonephritis				INTERVAL BETWEEN ONSET AND DEATH 14 days	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACC. DENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month Day Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1951, 19, to 10/13, 1958, that I last saw the deceased alive on 10/13/58, 19, and that death occurred at 2:40A M, from the causes and on the date stated above.						ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE Dr. Fred R. Gramse						DATE SIGNED	
PHYSICIAN'S NAME (Type)		Dr. Fred R. Gramse		South Division St., Salisbury, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/15/58		22c. NAME OF CEMETERY OR CREMATORIUM Parsons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson Co. Salisbury, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE OCT 17 '58		24b. REGISTRAR'S SIGNATURE C. E. Baker	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11906

CERTIFICATE OF DEATH

Reg. Dist. No.

11914

1. PLACE OF DEATH a. COUNTY Wicomico		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 3 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hebron					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		d. STREET ADDRESS 1 Church Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Ebenezer E. Harland		4. DATE OF DEATH Wright	Month October	Day 6	Year 1958				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/22/1885	9. AGE (In years last birthday) 72	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Ebenezer Wright		14. MOTHER'S MAIDEN NAME Rebecca Phillips							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO.		17. INFORMANT Hospital Records Address Mrs. Etta E. Wright (Wife) Church St.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO Arteriosclerotic cardiovascular disease with left hemiplegia (c)						INTERVAL BETWEEN ONSET AND DEATH 24 hrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Aortic stenosis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Doy, Year Hour o. m. p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County)		(State)	
21. I certify that I attended the deceased from June 30, 1958, to Oct. 6, 1958, that I last saw the deceased alive on Oct. 6, 1958, and that death occurred at 3:20 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <i>G. Kosmahl</i> M.D. Deer's Head State Hospital 10/6/58									
PHYSICIAN'S NAME (Type) G. Kosmahl, M. D.		Salisbury, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 9, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Spring Hill Memory Gardens - R.D.#		22d. LOCATION (City, town, or county) Salisbury, Md. (State)			
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND		24a. REC'D BY REGISTRAR DATE OCT 10 '58		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>			

STATE OF CALIFORNIA
CENSUS OF 1850

1850

1850

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11907 CERTIFICATE OF DEATH

11915

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury, Maryland		c. LENGTH OF STAY IN 1b 1 mo. 19 days					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First Elizabeth	Middle Maruel	Last Wynn				
4. DATE OF DEATH Oct. 5	Month Oct.	Day 5	Year 19 58				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 6/15/1895				
9. AGE (In years last birthday) 63	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0				
13. FATHER'S NAME Frank Maruel	14. MOTHER'S MAIDEN NAME unk	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unk			16. SOCIAL SECURITY NO. unk	17. INFORMANT Hospital Records	18. CITIZEN OF WHAT COUNTRY? USA
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Recurrent Cerebral Hemorrhage			INTERVAL BETWEEN ONSET AND DEATH 2 weeks				
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO Arteriosclerosis general							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m.		Month 19	Day	Year	20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Salisbury, Maryland
						(County)	(State)
21. I certify that I attended the deceased from Aug. 25, 1958 , to Oct. 5, 1958 , that I last saw the deceased alive on Oct. 5, 1958 , and that death occurred at 7:35 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>V. Juerman</i>	ADDRESS (Street, city or town, state) Salisbury, Maryland						DATE SIGNED Oct. 5, 1958
22a. BURIAL, CREMATION REMOVAL (Specify) Burial Oct 7 1958		22b. DATE THEREOF Oct 7 1958	22c. NAME OF CEMETERY OR CREMATORIUM Cambridge Cemetery		22d. LOCATION (City, town, or county) Cambridge		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Delmonte Funeral Service</i>		ADDRESS Cambridge	RECD BY REGISTRAR OCT 7 '58	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300	301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400	401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448	449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466	467	468	469	470	471	472	473	474	475	476	477	478	479	480	481	482	483	484	485	486	487	488	489	490	491	492	493	494	495	496	497	498	499	500	501	502	503	504	505	506	507	508	509	510	511	512	513	514	515	516	517	518	519	520	521	522	523	524	525	526	527	528	529	530	531	532	533	534	535	536	537	538	539	540	541	542	543	544	545	546	547	548	549	550	551	552	553	554	555	556	557	558	559	560	561	562	563	564	565	566	567	568	569	570	571	572	573	574	575	576	577	578	579	580	581	582	583	584	585	586	587	588	589	590	591	592	593	594	595	596	597	598	599	600	601	602	603	604	605	606	607	608	609	610	611	612	613	614	615	616	617	618	619	620	621	622	623	624	625	626	627	628	629	630	631	632	633	634	635	636	637	638	639	640	641	642	643	644	645	646	647	648	649	650	651	652	653	654	655	656	657	658	659	660	661	662	663	664	665	666	667	668	669	670	671	672	673	674	675	676	677	678	679	680	681	682	683	684	685	686	687	688	689	690	691	692	693	694	695	696	697	698	699	700	701	702	703	704	705	706	707	708	709	710	711	712	713	714	715	716	717	718	719	720	721	722	723	724	725	726	727	728	729	730	731	732	733	734	735	736	737	738	739	740	741	742	743	744	745	746	747	748	749	750	751	752	753	754	755	756	757	758	759	760	761	762	763	764	765	766	767	768	769	770	771	772	773	774	775	776	777	778	779	770	771	772	773	774	775	776	777	778	779	780	781	782	783	784	785	786	787	788	789	790	791	792	793	794	795	796	797	798	799	800	801	802	803	804	805	806	807	808	809	800	801	802	803	804	805	806	807	808	809	810	811	812	813	814	815	816	817	818	819	810	811	812	813	814	815	816	817	818	819	820	821	822	823	824	825	826	827	828	829	820	821	822	823	824	825	826	827	828	829	830	831	832	833	834	835	836	837	838	839	830	831	832	833	834	835	836	837	838	839	840	841	842	843	844	845	846	847	848	849	840	841	842	843	844	845	846	847	848	849	850	851	852	853	854	855	856	857	858	859	850	851	852	853	854	855	856	857	858	859	860	861	862	863	864	865	866	867	868	869	860	861	862	863	864	865	866	867	868	869	870	871	872	873	874	875	876	877	878	879	870	871	872	873	874	875	876	877	878	879	880	881	882	883	884	885	886	887	888	889	880	881	882	883	884	885	886	887	888	889	890	891	892	893	894	895	896	897	898	899	890	891	892	893	894	895	896	897	898	899	900	901	902	903	904	905	906	907	908	909	900	901	902	903	904	905	906	907	908	909	910	911	912	913	914	915	916	917	918	919	910	911	912	913	914	915	916	917	918	919	920	921	922	923	924	925	926	927	928	929	920	921	922	923	924	925	926	927	928	929	930	931	932	933	934	935	936	937	938	939	930	931	932	933	934	935	936	937	938	939	940	941	942	943	944	945	946	947	948	949	940	941	942	943	944	945	946	947	948	949	950	951	952	953	954	955	956	957	958	959	950	951	952	953	954	955	956	957	958	959	960	961	962	963	964	965	966	967	968	969	960	961	962	963	964	965	966	967	968	969	970	971	972	973	974	975	976	977	978	979	970	971	972	973	974	975	976	977	978	979	980	981	982	983	984	985	986	987	988	989	980	981	982	983	984	985	986	987	988	989	990	991	992	993	994	995	996	997	998	999	990	991	992	993	994	995	996	997	998	999	1000	1001	1002	1003	1004	1005	1006	1007	1008	1009	1000	1001	1002	1003	1004	1005	1006	1007	1008	1009	1010	1011	1012	1013	1014	1015	1016	1017	1018	1019	1010	1011	1012	1013	1014	1015	1016	1017	1018	1019	1020	1021	1022	1023	1024	1025	1026	1027	1028	1029	1020	1021	1022	1023	10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